Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 29501

		For State egistrar	Cen	tificate of D	eath	Reg	g No	0 2550
Physician Medical Examine	/ 1 er	Decedent's Name (First, Middle, Last	nore	-		September	Day Year 14, 2006	3. Time of Death 2124 hrs
	4	a. Facility Name (if not institution, give Johns Hopkins Hospital	e street and number)		City, Town, or Location of I altimore		4c. County of Death	
Funeral Director	<i>t</i> 0	Social Security Number 6. Se 21'7-90-4022 1			Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Birth	MM/DD/YYYY) 9 Birth Foreign Cou	
nd show any	1	Jsual Residence of Decedent  Oa. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits 1 Yes 2 No
the Maryland 3a or 28a-f sh otified at once		0e. Street and Number	- Aue Apt &		f. Zip Code	10	g Citizen of What Count	ry?
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene from the file of the sinarked other than "uatural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	1	Married Status     Never Married 2' Married     Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year		ecedent of Hispanic Origin specify Cuban, Mexican, P s 2 No specify:		14 Race - Americ White, etc. Specify.	an Indian, Black,
OO36  within 72 hours aft giene her than "natural" Andical Examine	ઽ⊢	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	or Dates.	16a. Decedent's l	Jsual Occupation (Give kir of working life DO NOT us	nd of work done se retired)	16b. Kind of Business/In	dustry
21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica	) [	7. Father's Name (First, Middle, Last)		Mana	18 Mother's	Name (First, Middle, M	13 lock P	Suster Vicko
D 21215-003 should be filed withi and Mental Hygiene is marked other it natic event, the Med		19a. Informant's Name/Relationship (T	ype, Print) Wife	19b. Mailing Ad	1	er or Rural Route Num	ber, City of Town, State,	Zip Code)
ore, MD es I and 2 sho of Health and If item 27 is her traumati	2	20a. Method of Disposition  1 Burial 2 Cremation 3			(Name of cemetery,	Baltimor.	20c. Location - City or 1	Town, State
Baltimore, permit Pages I a Department of He Important: If ite Important: If ite Injury or other to	2	4 Donation 5 Other Specify. 21. Signature of Funeral Service Licen	h	Ng Memo	e and Address of Facility	9/21/06 Chatman-H	Mandalls	town Md
Physician /Medical	-	23a. Part Enter the disease, or complete failure. List only one cause on ea	ach line.	Do not enter the r	O Reasters  node of dying, such as car		Ba Hrim of est, shock, or heart	Approximate Interval Between Onset and
xaminer		or condition resulting in death)	Gunshot Wound to Bac Due to (or as a consequence of					Death
led Institute of the second of	Jallie I	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of					
		d.	Due to (or as a consequence of		50.0/05/04 PT			
	I/IMedical	F FEMALE.	23c. If yes, outcome of pregi		59,9/25/06 TT		23d Date of delivery	
- E 60	Pnysician/ii	3b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of de	2 Fetal	death 3 Ectopic p	pregnancy		ay Year
that the death certification and by the attending detached for use as:	by Pny	Part II. Other significant conditions	3 Olikilowii	esulting in the unde	erlying cause given in Part		bacco use contribute to t	
cords, P.C. law requires that has heen signed be successful to be deta	Completed					24a. Was a autop:	an 24b. Were aut	opsy findings available ompletion of cause of
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Vital I	e n	25. Was case referred to medical examiner?	Hospital: 1 Innatient 2	ER/Outpatient 3	26.Place of Death (C		Residence 6 Other	
Division of Vital Records, P.O ra or Attending Physician: The law requires that the stander of the properties of the pro	ion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a Date of Injury (Month, Day Year) Sep 14, 2006	28b Time of Injui 2035 hrs		28d. Describe h	now injury occurred	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate has been signed death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	be 28e Place of Injury - At he		actory, office building, etc	or Town, S	Street and Number or Ruitate) tead Street, Baltime	
To the Hospita within 24 hours To the Funeral completely filler	न्		ian: To the best of my knowled r:On the basis of examination a and manner stated		, in my opinion, death occi			
		29b Signature and title of certifier	Halle	n	29c. License number O.C.M.E.		September 15, 2	
17		30. Name and address of person who Carol Allan, MD Assista	ant Medical Examiner	111 Penn Str	eet, Baltimore, MD	21201		
Sta Registr	~	31. Date filed (Month, Day, Year) SFP 1 8 200	32 Registrar's Signat	re Aposta	20			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Shirley Ann Gibson September 16 2006 10:40a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 9 1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🛱 F 213-40-1427 Yrs. MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-1 ehow ? is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Modical Experiment mat be notified at MdBaltimore Owings Mills 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 5125 Deer Park Road 21117 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturel", or item any injury or other treumatic event, the Medical Examinations. Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. Public Schools cafeteria manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Boyd Palmer Bertha Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas F. Gibson Jr. (son) 5125 Deer Park Rd., Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lake View Memorial 9-22-06 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Parge Jaight erspert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mekspir **Physician** chama months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and shed for use as the burial-transit the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) n signed by the a ld be detached for 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes if or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မှ 2 ER/Outpatient 3 DOA hours after death. inerel Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of (anth Done Busness Janathan ushniv 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year SEPTEMBER 8, 2006 (13 W CE APT. B-1 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death GLEN CIRCLE ANNE ARUNDEL RIDGE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 214-24-8445 1 M 2 Months Yrs. JANUARY 22, 1929 MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No GLEN ANNE BURNIE MD ARUNDEL 10e. Street and Number APT. B-1 10f. Zip Code 10g. Citizen of What Country? 6915 GLEN RIDGE CIRCLE 21061 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 DWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MOTOR VEHICLE ADMIN. CLERICAL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE KROENING MAE IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEPHEW 20b. Place of Disposition (Name of cometery, crematory or other place) JOPPA GORSCH 21085 MICHAEL DR Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
4 Donation 5 Other (Specify) ENTCHBMENT EDAR HILL CEMETRLY 9-13-06 BALTO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 RITCHIE HWY BALTO 31997 FUNERAL SERVICE romerous GONCE K 23a. Part 1. Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Trom ye le 5/06 Due to (or as a consequence of): Sequentially list conditions, if any, reading to infilterate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a onsequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 1es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner certificate be executed o Records, of Vital Division or Attending within 24 hours after death. To the Funerel Director: A Hospital

**Physician** 

/Medical

Examiner

Director

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Certification:

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(Check only one)

29b. Signature and title of certifier

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

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State Registrar

31. Date filed (Month, Day, Year) HCBARO

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Pennington Avenue BAltimore

29c. License number

1 🖵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32. Registrar's Signature

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н	Funeral Director		5. Social Security Number 218-03-3321	6. Se	X /.Age □M 2口F		is <i>t birtnd</i> ay) Yrs.	Months		Hours Min.	8. Date of Bi	nn ay, Year,	) 5	Cour	
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	sth with the Maryler 23s or 28s-f ehow	la l	1482 BOLLING	ER RO	AD				21157				U.S.	Α.	
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	127 E		RICHARD GRAH	IAM /	SON		1482	2 BOL	LINGER	ROAD	WESTM	INST	ER, M	D 2	1157
ore	es 1 a of Hea f Item r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem	ation 3 🗆	Romanal from State	20b. Pla	nce of Dispo	sition (Na	me of other place)		Date	20c. L	ocation - Ci	ty or To	own, State
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Baltimore,	permit. Pages Depertment of I Importent: If Its eny Injury or o		21. Signature of Foneral Se	orvice Licens	Muse	1			nd Address of	. 20	DL LEVI	NSON	& BR	0S.	, INC. MD 21208
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Ě	/Medical		resulting in death)		a Due to (or as a	a consegue		077	1.0						
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	ad sit	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~	Due to (or as a	a conseque	ence of):								
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Division of Vital Records,	The law requires that the death cereste has been signed by the ettendir page 2 should be detached for use	Ď	Part II. Other significant co	enditions co	ntributing to death bu	it not result	ting in the ur	nderlying (	ause given in	Part I.	-				e cause of death?  ably 4 □Unknown
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	To the Hospitel or Attending Physicien: The i within 24 hours after death.  To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Ce (Check only 2 ☐ Me	rtifying Phy dical Exami	sician: To the best of ner: On the basis of and manner stat	examination	ledge, death on and/or inv	occurred	at the time, d , in my opinio	date and place, on, death occur	and due to the red at the time,	cause(s) date and	and mann d place, and	er as st	ated. the cause(s)
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i	) \	Ì	30. Name and address of p	erson who co	ompleted cause of de	eath (Item 2	23a) (Type, F	Print)	0000 Balti						
1	-0		31. Date filed (Month, Day,	Year)	132 Ranietra	r's Signatu	ול דיי פן		10 6/4/	men 1	VD 515	-//			
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			4 15	partment of Health and Mental ertificate of Death	
	Physic	ian	1. Decedent's Name (First, Middle, Last)  Josephine A.M. Greiner	Mont	
	/Medi Exami		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ember 8, 2006   8:45 AM M
			Heritage Center Nursing	Dundalk	Baltimore
T.	Funeral Director		5. Social Security Number  216-12-5415  Usual Residence of Decedent  6. Sex 1 M 2 F 83  7. Age (In yrs. last birthda 7 Yrs.	Months Days Hours Min. (Mont	of Birth h, Day, Year) 9. Birthplace (State or Foreign Country) Unk
	ryland how		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
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	eme 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	or No- 14. Race - American Indian,
36	s afte	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	Specific
9-0	2 hours		15. Decedent's Education 16a. De	edent's Usual Occupation un	white  16b. Kind of Business/Industry
21215-0036	within 7 ene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of working DO NOT use retired)	
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	if Health Itam 27 other tr		Herita e Center Nursin 723  20a. Method of Disposition 20b. Place of Dis	2 German Hill Road Dund	a1k, MD 21222 20c. Location - City or Town, State
mor	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☑ Donation 5 ☐ Other (Specify)	ematory or other place)	20c. Location - City of Town, State
Baltimore,	permit. Par Depertment Important: eny Injury			22. Name and Address of Facility State Anatomy Board 655 Baltimore, MD 21201	W. Baltimore Street
77			23a. Part 1 Enter the disease or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirate	ory arrest, Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	NYOCARDIALINF	ARCTION Consuland Acethy
	Examiner and spring-transit e puriel-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ARTERY DISA TAL HYPERTE	ASE SYEARS ENSION 25 YEARS
9 x	leath certifica attending ph I for use as th	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		
P.O. Box	the by th	Physician/Med	in the past 12 mosths?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
	law requires that as been signed b 2 should be det	by	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute to the cause of death?  1 Yes 2 10 3 Probably 4 Unknown
œ	The la ate has page 2	Completed			Was an autopsy available prior to completion of cause of death?  ■ 22 No 1 Yes 2 No
Zi X	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   I   I   I   I   I   I   I   I   I	26. Place of eath (Check o	
of	Attending Physician: r death. sector: After this certific. by the funeral director.	n: To	27. Mann of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Descri	Residence 6 Other (Specify)  Tibe how injury occurred
Sior	ttending I death. ctor: After / the funer	catio	1 ✓ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work?  M 1 □ Yes 2 □ No	
<u>\S</u>	or Att after d Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, so building, etc. (Specify)	treet, factory, office 281. Locatii City or	on (Street and Number or Rural Route Number, Town, State)
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place, and due to	the cause(s) and manner as stated
	the Ho nin 24. the Fu	Medical	one) and manner stated.	nvestigation, in my opinion, death occurred at the tr	me, date and place, and due to the cause(s)
)	To To Com	2	29b. Signatura and Julippol condition	29c. License number	29d. Date signed (Month, Day, Year) SERTEMBERS, 2006
			30. National appropriate for parson who comprehences of death from \$30) (Type	Signo A RITCHIE	HIGHWAY;
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature SEP 1 6 2006	who will be the service of the servi	

State of Maryland / Department of Health and Mental Hygiene - For Stata Ragistras Reg. No. 2006 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Lee 10 PM Francis Hicks SEPTEMBEL. 11 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMAR I TAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, ) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⊠** M 2□ F 67 Director April 1, 216–34–7733 Mary land Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a 210 N. Rose Street 21224 United States Funeral or Items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. within 72 hours after I ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Asbestos Pipe Coverer 9 permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine M. Tyler Frank Feliz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 N. Rose Street, Baltimore, MD Consetta M. Hicks/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State September 18 ō Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 2006 Signat 22. Name and Address of Facility Rendon-Bailey Funeral Home, P. A. in, 2818 E. Baltimore Street, Baltimore, MD 21224 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEP SIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NICELS DECUBITALS LOWER ETRONITES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit LING INFECTION end that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical KONEY STAG G DISCATO IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown CORON AR Y 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SEVERE PERIPHER A3CHUAR 1 Yes 1 ☐ Yes 2 ☐ No of Vital 2 X No or Attending Physicien: 25. Was case referred to medical examiner? certifi Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Medical Certification; 28b. Time of 28d. Describe how injury occurred Division Injury 1 SNatural 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ATTONDING PHYSIUM 29c. License number 29b. Signature and title of dertify 29d. Date signed (Month, Day, Year) STATEMBER D0062239. 12 2000 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pason BAT (MORE 5601 LOCHRAVEN, BIVD:, BATTEMON, MD 21239 M.D. MAW 00, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 8 2006 Registrar

		Maryland / Department of He Certificate of D	aith and Mental Hygi	•
Physician	1. Decedent's Name (First, Middle, Last) Harvey J. Hardesty		2. Date of Death Month SEDFOMGE	Day Year
/Medical Examiner	4a. Facility Name (If not institution, give street and number Sinai Ruspital of Balhw		wre	4c. County of Death N/A
Funeral Director	. <del>M</del>	Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min. 8. Date of Birth (Month, Day, 09/01/1	year) 9. Birthplace (State or Foreign Country) 932 Maryland
Maryland 1 • how	10a. State 10b. County MD Carroll	10c. City, Town or Location  Eldersburg		10d. Inside City Limits 1 ☐ Yes 2 🚰 No
with the	10e. Street and Number  2023 Unit 3C, Rudy Serra	10f. Zip Code Drive 21784	10	Og. Citizen of What Country?  United States
Ind 21215-0036  be filed within 72 hours after death with the Maryland tall hygiene. Indicate them "naturel", or tieme 23e or 28e-1 ehow event, the Medical Examiner must be routhled at Be Completed by Funeral Director	11. Marital Status  12. Was Decede Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced 2 Married 2 Married 1 Yes 7 Vear or Date:	nt Ever in U.S.  \$?  \$\text{S} \text{No}   13. Was Decedent of His	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify:White
AAL UE Y  21215-0036  ed within 72 hours all Spiene. Per then "naturel", or It, the Medical Exam. Completed by F		16a. Decedent's Usual Occupati (Give kind of work done du life, DO NOT use retired	on ring most of working	6b. Kind of Business/Industry
N BEE	12 2 17. Father's Name (First, Middle, Last)	Electrical Tec	chnician I 8. Mother's Name (First, Middle, M	Manufacturing kaiden Sumame)
	Harvey J. Richard Hardest	У	Dorothy Marie Ja	ames
See 2 2 2	19a. Informant's Name/Relationship (Type, Print)  Darlene Spurrier (Sister)		d Number or Rural Route Number, ~ Way #303 . Glen	City or Town, State, Zip Code)  Burnie, MD. 21060
Hear Hear	20a. Method of Disposition	20b. Place of Disposition (Name of		20c. Location - City or Town, State
jffle () Baltimore, permit. Pages 1 at Inportent: if item any injury or othe anger.	1 Peurial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify)	Loudon Park Cemete	ery 09/16/2006	Baltimore, Maryland
Balti permit. Depertin Importe any inju	21. Swatting of Fig. 1 Privile Vicenses			neral Home, Inc. more, Maryland 21229
Physician /Medical	resulting in death)	serebal hemorrhage		st, Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physicien: The law requires thet the death certificett within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification; To Be Completed by Physician/Medic		e of pregnancy 2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
rds, P quires thet in signed b uld be deta	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given	in Part I. 23e. Did tob.	acco use contribute to the cause of death? s 2 151 No 3 Probably 4 Unknown
Il Record The law requir Sate has been si page 2 should	Aprial fibrillation		24a. Was an autopsy perform	prior to completion of cause of
f Vitalysicien: sysicien: is certification director.	25. Was case referred to medical examiner?	Othor	6. Place of Death (Check only one	
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Division ( Ital or Attending F is after death.  Tel Director After Tel in by the funer Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of the building.	M 1 ☐ Yen njury - At home, farm, street, factory, office atc. (Specify)		eet and Number or Rural Route Number, State)
Divi	one) Medical Examiner: On the basis		ion, death occurred at the time, da	te and place, and due to the cause(s)
To the withing Comp	29b. Signature and title of certifier	29c. License r	number 29	d. Date signed (Month, Day, Year)
47	30. Name and address of person who completed cause of	death (Item 23a), (Type, Print)	000	d. Date signed (Month. Day, Year) Potombeor 13, 2006  e Ave, Balkinwe MD 21213
1) 0	OSCAR V. BAILON (MB) SIN 31. Date filed (Month, Day, Year) 32. Regis	wiltOspetal of Bolhuse	, 2401 W. Belveder	e Ave, Baltinure MD ZKIS
State Registrar	SEP 1 8 2008	seems of pooles		

State of Maryland / Department of Health and Mental Hygiene 2006 29508 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10 2006 Hatcher DWayne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Shock Trauma University of aryland If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1-11-1968 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 Jm 2 □ F Months 38 Md. 215-82-8319 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland 10a State 10h County ir then "natural", or items 23e or 28e-f show the Wedical Examinar must be notified at 1X Yes 2 No Anne Arundel Co Severn Md. Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21144 7904 S. Cartier Court USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Office Movers Laborer 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othin any liquy or other traumatic event size. Be Hatcher Farzer Dorsey Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7904 S. Cartier Court, Severn, Md. Uncle Harry Harrison 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Md. Meadowridge Cem. 9-16-06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Transmalic day **Physician** Severi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 从 Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending abusinen and to the Funeral Director: After this certificate has been signed by the attending abusinen and signed by the ettending physicien and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 4 □Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No Division of Vital 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28c. Injury at Work? 28b. Time of fnjury 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year) 1 Natural 5 Pending 2:550 M investigation -9-2006 2 Accident 3 ☐ Suicide the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide Aprobam Road, Hanover, Mary lamo Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P13154 9-10-2006 des 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Greene Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrer	State of Maryland /	Department of Certificate of		ental Hygien	4000	29509
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) DOROTHY	HAYES			2. Date of Death Month Date of Death DEPTEMBER	ay Year	3. Time of Death 2:40Am
<b>)</b>	Examin		4a. Facility Name (If not institution, give str.	25 HOSPITA	L BAL	or Location of Death  HMORE		c. County of Death	
	Funeral Director	0	5. Social Security Number  6. Sex  1 N  Usual Residence of Decedent	7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days		3. Date of Birth Month, Day, Year 30, 19	Coun	ace (State or Foreign try)
	death with the Maryland me 23a or 28e-f ehow r nutt be collited at	tor	10a. State 10b. County		wn or Location			10	od. Inside City Limits
	h with the 23a or 284 at be not	ai Director	10e. Street and Number 32/9 Pressman	,	10f. Zip Code	216	10g. C	itizen of What Coun	try?
		by Funerai	11. Marital Status 12 1 Never Married 2 Married Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Co If Yes, Give	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spec ban, Mexican, Puerto R o Specify:	ify Yes or No- ican, etc.)	14. Race - America Black, White, &	
00-017	within 72 hours after ene. then "naturel", or Ite	Completed b	15. Decedent's Educa (Specify only highest grade of	Year or Dates: tion 16 completed) College (1-4or 5+)	life. DO NOT use retire	during most of working	9	Kind of Business/Ind	
717 BUI	be filed witt tal Hygiene d other the	Be	17. Father's Name (First, Middle, Last)	/	HOUSEWIK	18. Mother's Name (		n Sumame)	C·
Maryla	2 should and Mer le marke raumatic	ဥ	19a. Informant's Name/Relationship (Type	1- 11 3	9b. Mailing Address (Stree	1 -0 1	,		1
nore, r	000		20a. Method of Disposition 2 Burial 2 Cremation 3 Ren	20b. Place cemet	of Disposition (Name of tery, crematory or other plane)	ace) Da	CleNOSNI.	ocation - City or To	wn, State
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	Physician		23d. Part1 Enter the disease, or complica spock, or heartfailure. List only one transdate Cause (Final disease or condition	tions that caused the death. Do		ring, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	CO RO WA	e of): Ry ART				
,0079	icate be executed physicien and s the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequence					
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on or v	To the Hospitel or Attending Physicien: whith 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	မ	1 ☐ Yes 22 No Hos		Time of 28c. Injury W	ther: 4 Nursing Hom ury at 28 ork? Yes 2 No	e 5 Residence		)
DIVISION	tel or Atter rs after dea el Director ed in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	3 28	Bf. Location (Street a City or Town, Sta	and Number or Rura te)	Route Number,
	the Hospl in 24 hou the Funer	edicai	one)	ian: To the best of my knowled r: On the basis of examination a and manner stated.	and/or investigation, in my	opinion, death occurred	d at the time, date ar	nd place, and due to	the cause(s)
)	To To	Σ	29b. Signature and title of certifier  ROPER R	Cru Z m		030355	1	ate signed (Month, l	
	3		30. Name and address of persop who com	pleted cause of death (Item 23a	(Type, Print) BO	NSEC	ours	Hosp	12,2006 ITAL
2 (2)	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Aporta				

Physicia		1 - For Amend item#7, per Registrar  1. Decedent's Name (First, Middle, Last)  The state of the	State of Marylan rDVR, 0859,9/18/0	Oer	tificate of	Death	2. Date of Deat Month	g. No.	106 20%	2951 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give Nov-Wusst  5. Social Security Number 6. Sec	Hospital	lo de hijsh da i	4b. City, Town, of Rand  If Under 1 Year	r Location of Dec	foun	Bal	of Death	
uneral irector			M 2□ F 44 +	Yrs.	Months Days	Hours Mi		962	9. Birthpla Countr	ce (State or Foreig y)
28a-f show	ector	10a. State Baltimo	ore Owi	y, Town or Loc ngs Mil	ls			0 - 00		d. Inside City Limit: 1 ☐ Yes 2 M No
ust be n	Funeral Director	1926 Hillside Dr			10f. Zip Code 21207			0g. Citizen of 1	wnat Count	y :
er, or iteme Examiner n	by	11. Marital Status  1 ☼ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If	as Decedent of H Yes, specify Cubi ☐ Yes 2 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	Bla	ce - America ck, White, et y.white	c.
marked other then "naturel", or iteme 23e or 28e-f show imatic event, the Medical Examinar must be nutified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give k	ent's Usual Occup and of work done O NOT use retired equipmen	during most of w d)	rorking	16b. Kind of B	_	•
arked otner atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Philip Walter Ho	wes				ame (First, Middle, M		ne)	
27 is m r treum		19a. Informant's Name/Relationship (Ty Dorothy Howes (mot					Rura <i>l Rout</i> e Num <i>ber.</i> Joodlawn,			Code)
important: if item 27 is marked eny injury or other treumatic ev once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State M+		ition (Name of atory or other plan Cemete:			20c. Location unshine		n, State
eny injudence		21. Signature of Funeral Service Licens	Herbert	22. P	Name and Addre	ss of FacilityHa	ight Fune sville, M	ral Hor	ne & C	hapel
VSICIS 9 DUI	Icai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  Due to (or as a conseq  d.	uence of):						
or use as t	Physician/Medi	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 🗆	Ectopic pregnancy Other (specify)	′			ite of deliver	r lay Year
n signed by the auld be deteched f	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause gn	ren in Part I.		pacco use contes	tribute to the	cause of death?
page 2 should	Completed						24a. Was a autops perform	y ned?	prior to com death?	y findings availa pletion of cause
this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	lospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient	3□ DOA Ott		eath Check on on Home 5 Reside		ner (Specify)	
After	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	yat k? Yes 2 □No	28d. Describe ho						
5 g		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ý) 			28f. Location (St City or Town	, State)		
To the Funeral D completely filled in	Medical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Madical Exami	sician: To the best of my kno nar: On the basis of examina and manner stated.	wiedge, death tion and/or inve	occurred at the tile estigation, in my o	ne, date and pla ppinion, death oc	ce, and due to the ca curred at the time, di	luse(s) and ma ate and place,	anner as sta and due to t	led. he cause(s)
To the	Σ	29b. Signature and title of certifier	32 //		29c. Licens	e number	819 3 300+1	9d. Date signe	d (Month, D	ey, Year)
58		/ //www			10	036	811 -	epise	mari	, , ,

			For Stete Registrar	State o	f Marylan		artment of rtificate of		l Mental Hy	giene Reg. No. 2 (	006	29511		
	Physici	an	1. Decedent's Name (First, Middle,	Last)		-			2. Date of De	Day 10	Year	3. Time of Death		
	/Medic	al	Bobby Lee  4a. Fecility Name (If not institution,	Horton	Sr.		4h Oir True	and position of Do	Septer	4c. County	2006.	11:4/AM		
	Examin	er	Union Memorial		тоөг)			or Location of De	ain	4c. County	orDeath			
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	imore	rs. 8. Date of Bir	th Vanel	9. Birthpl	ace (State or Foreign		
	Director		228-62-0326	1 XM 2 ☐ F	61	Yrs.	Months Days	Hours M	n. (Month, Da 03-31-		Count Ohi	• •		
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits		
	Maryl.	ī	Maryland				timore					1 X Yes 2 No		
	r 288	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	ry?		
	13a o	alD	628 36th. Stree	t				21218		U.S.A	١.			
	hours after death with the Maryland turet', or Items 23s or 28s-f show at Expollmentment be nutilised at	Funeral Director	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)- 14. Rad Bla	ce - America			
36	or i	by Fi	1 ☐ Never Married 2 🕅 Marrie 3 ☐ Widowed 4 ☐ Divorced	16 Van Ci	2□No ⁄e ates: Unkno		1 ☐ Yes 2 💹 No	Specify:		Specif	y: Bla	ck		
8	Phou	edt	15. Decedent	s Education	ates. UIIKII(	16a. Dece	dent's Usual Occu	pation		16b. Kind of B	usiness/Ind	ustry		
215	within 72 ene. then "na!	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	I-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of v ed)	vorking					
7	e filed within al Hygiene. I other then vent, I're Mo	Соп	11		,	Gener	cal Cont	7		Self E		ed		
and E	be fill d out	Be	17. Father's Name (First, Middle, L Emora Devron H						ame (First, Middle		ne)			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healin and Mental Hygiens is the 23a or 28a-f show then 21 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Madical Exp. ther must be nutified at	ဥ	19a. Informant's Name/Relationsh			19b Mailir	na Address (Stree		n Ma <b>e</b> Wil Rum Route Numb		State Zin	Code)		
	nd 2 suith ar		Tammy Cook / Da			1			altimore,					
Je,	other tre	,	20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of natory or other pl	ace)	Date	20c. Location	- City or Tov	vn, State		
Ē	Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Se		State		Cemeter		22/2006	Landsdo	wne, J	Maryland		
Baltimore,	per nit. Pages ' Department of h Important: If its any injury or ot once.		21. Signature of Funeral Service L	iodream					he Derric					
_	₹0 = 4 d			CVE								and 21215		
			23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final											
	Physician /Medical		disease or condition resulting in death)	a	PS1S (or as a conseq							< 7 days		
	Examiner			ME	TASTA	TIC	PANCE	FATIC	CAN	CER		> 1 month		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	(or as a conseq	uence of):				-				
	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. AC9	WIE		MINE I	DEFICI	ENCY S	YNDI	PHE	>1 month		
8760,	be ex ician burial	al E)	in document and the second	Due to (	or as a conseq	uence or);								
687	ficate physical physi	edicai		d							U			
Вох	death certifica attending pt d for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant		come of pregna					23d. Da	te of deliver	у		
	ne death the atte	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		oirth 2 ∏ Feta nant at time of d		Ectopic pregnand Other (specify)			Mo	onth [	Day Year		
0.0	ta co	Phy	9 Unknown											
	8 5 8		Part II. Dther significant condition	is contributing to de	eath but not res	ulting in the u	nderlying cause g	iven in Part I.		obacco use con Yes 2 □ No	tribute to the	e cause of death?		
Records,	w requires been sign should be	etec												
Re	The law ate has b page 2 st	Completed								ormed?	death?	sy findings available pletion of cause of		
Vital	sician: Th certificate rector, pag	0	25. Was case referred to medical	3				26. Place of D	1 ☐ Yes eath (Check only o		1 ☐ Yes 2	2∐ No		
<u>&gt;</u>	d is	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 121	npatient 2	ER/Outpatier	t 3 DOA	her	Home 5 ☐ Resi		ner (Specify)			
			27. Manne of Death 1 ☑ Natural 5 ☐ Pending	28a. Date ( (Moni	of Injury th, Day Year)	28b. Time of Injury	W	ury at ork?	28d. Describe	how injury occur	red			
sio	Attending r death. Sctor: After by the fune	cati	2 Accident investig	ation	-6.1-1			Yes 2 No	001	0				
Division	after a Direc	Certification:	4 Homicide determin	289. Place	ng, etc. (Specify	ome, tarm, str y)	eet, factory, office		City or To	Street and Numb wn, State)	er or Hurai	Houte Number,		
_	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physicien: To the	best of my kno	wledge, death	occurred at the	ime, date and pla	ce, and due to the	cause(s) and ma	anner as sta	ited.		
	he Ho in 24 I he Fu pletely	Medical	(Check only 2 Medical E	xeminer: On the ba	asis of examina ner stated.	tion and/or in	estigation, in my	opinion, death oc	curred at the time,	date and place,	and due to t	the cause(s)		
	To the I within 2 To the I	Σ	29b. Signature and title of certified	70		1 10		ise number		29d. Date signe		4.1		
,	0		- Jeverpl	pero	voe,	MD	AT.	24389	46	septen	nber	14,2006,		
/	, В		30. Name and address of person v	no completed caus	e of death (Item	23a) (Type,	Print) // AM	DON MA	THORIA	1 40	EPIT	14,2006. AL, MD		
	Sta	te	31. Date filed (Month, Day, Year) SFP 1 8	32 0	egistrar's Signa	tyre		0,0 ,00	-/-//	C 1102	31 ( /	(-),		
3	Registr		SEP 1 8	2000	wire s	The Asset	ende							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2951:
State of Maryland / Department of Health and Mental Hydians

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 7:30aw **Physician** Haw Kes 2006 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3614 Wabash Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours Yrs 83 Director 225-26-0631 8-23-23 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show of Health and Menial Hygiene. Item 27 is marked other then "neturel", or Iteme 23s or 28s-1 show other traumatic event, Its Medical Exaction must be notified at 1 X Yes 2 ☐ No Director MDn/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 3614 Wabash Avenue 21215 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. It portant: If item 27 is marked other than 'neturel', or item any injury or other traumatic event, the Mental any injury or other traumatic event, the Mental any injury or other traumatic event, the Mental and State. Specify: African-1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced <u>American</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) 11th Scarfer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 Eddie S. Hawkes Daisy Fitzgerald ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3614 Wabash Avenue, Balto, MD 21215 Thelma D. Hawkes/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem. Park 9/15/06 Arbutus, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tylie F/H P.A. of Balto. 21. Signature of Puneral Service License 9200 Liberty Rd., Randallstown,MD 21133 2 a. 2 ml. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final 4 years Metastatic prostate **Physician** disease or condition resulting in death) /Medical **Examiner** netasta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ¥ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home ome 5 Residence 6 □Other (Specify)
28d. Déscribe how injury occurred Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral [ Certifying Physitian: To the best of my knowledge ideath occurred at the time idate and place, and due to the dause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D31586 Sept 12, 2006 ausov any 30. Name and a dress of this on who completed cause of death (Item 23a) (Type, Print)
NANCY A DAWSON 22 South Greene St Baltimore MD 2720 State SEP 1 6 2006 Registrar

			For State Registrar	State of Mary	land / Dep Ce	partment of ertificate of	Health and Death	Mental Hyg	iene <sub>eg. No.</sub> 2006	29513
	Physici /Medic	_	1. Decedent's Name (First, Middle, Las	BELL	- H	AWKI	NS	2. Date of Deat Month SEP	13 2006	3. Time of Death 7:01A. M.
)	Examin		4a. Facility Name (If not institution, give Howard County Ger	neral Hospit			or Location of Deat Columbia		4c. County of Death Howard	
	Funeral Director		5. Social Security Number 6. Sec. 218-24-6688 10  Usual Residence of Decedent	M 2⊠F	yrs. last birthday 74 Yrs.	Months Days		8. Date of Birth	Yegg2 Mafy	place (State or Foreign
	Maryland -f ehow	tor	10a. State 10b. County MD Howard	10	c. City, Town or i					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	al Director	10e. Street and Number 6334 Cedar Lane			10f. Zip Code 21044			Og. Citizen of What Cou United Stat	
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be incitiled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer o Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
21215-0	- 60	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		redent's Usual Occur re kind of work done DO NOT use retir Se Keeper	upation e during most of wo ed)	rking	16b. Kind of Business/In Domestic	ndustry
Maryland 2	should be filed within a Mental Hygiene. marked other then imatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Raymond Clay, S	r.				me (First, Middle, i		
	nd 2 salth ar 27 io		19a. Informant's Name/Relationship (7 Joseph Hawkins /	Son	932	Amer Dri	et and Number or R .ve Fort V	ural Route Number Vashingto	n, MD 20744	p Code)
altimore,	permit. Pages 1 e Department of Hes Important: If Item eny Injury or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	comotory, ci	position (Name of ematory or other pl Cremato	RY	2006		own, State
Ba	Depar Impor		21. Signature of Funeral Service Licent	1- marich	7	1922 Fo:	rest Driv	e Annapo	olis, MD	
5	Physician and Washington and Saminer as the burial-transit	edicai Examiner	shock, or heart failure. List only of lamediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	columns of):	1 .	ive Pul		Disease	Approximate Interval Between Onset and Death  4 years  4 years
P.O. Box 6	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	B Ectopic pregnan	су		23d. Date of delin Month	very Day Year
rds, P	quires thet an signed b	ρ	Part II. Other significant conditions or	ontributing to death but n	ot resulting in the	underlying cause g	given in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	,
Division of Vital Records,	2 8 8	Completed						24a. Was a autops perform 1 □ Yes	y prior to co	opsy findings available ompletion of cause of
5	s certif	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 X ER/Outpati	ent 3 DOA	ther	ath <i>Check only or</i>	ence 6 Other (Spec	4.0
ion of	Attending Physician: or death. ector: After this certifice by the funeral director, p		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time	of 28c. Inj			ow injury occurred	197
Divis	ospital or Atte hours after des uneret Directo ly filled in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	At home, farm, Specify)	street, factory, office	9	28f. Location (Si City or Town	treet and Number or Rui n, State)	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeret Director: After this certificate hy completely filled in by the funeral director, page	edicai	one) 2 Medical Exam	ysicien: To the best of m siner: On the basis of ex- and manner stated	amination and/or	investigation, in my	opinion, death occ	urred at the time, d	ate and place, and due	to the cause(s)
		Σ	29b. Signature and title of certifier  Alle dor	Ali kha	u Mi	29c. Lices	nse number 0433	323	Sep. 13	Day, Year) 3 2006
	5		30. Name and address of person who do	ickory	Ride	e, Print) AR	CPA ad, C	ALIM	CHAI MI	21044
	Sta Regist		SEP 1 8 200	Registrar's	Signature Signature	elle				

	For State Registrar  1. Decedent's Name (First, Middle)		ryland / Depa <i>Cel</i>	artment of rtificate of		ad Mental H	Reg. No.	006 2951		
Physician /Medical	Michael N. Jon	es		4h Cihi Tour	as Lagation of	Month 09	09	Year 2006 3075		
Examiner Funeral	4a. Facility Name (If not institution     3700 Aster Rid     5. Social Security Number	ge Court 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Yea	ct Heig	hts Hrs. 8. Date of I	Pri	nce George's  9. Birthplace (State or Fore		
Director	215-11-9780 Usual Residence of Decedent	1 <b>☆</b> M 2□F	36 Yrs.	Months Days	s Hours	Min. (Month, 12–4–)	Day, Year) L <b>969</b>	DC		
death with the Maryland me 23a or 28e-f show ground be notified at neral Director	MD Princ  10e. Street and Number	e George's	10c. City, Town or Lo				10g. Citizen	of What Country?		
urs after al', or its vernine by Fui	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No		2074 Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🗷 No	Hispanic Origi ban, Mexican,	n? (Specify Yes or Puerto Rican, etc.)		A Race - American Indian, Black, White, etc. Black		
filed within Hygiene. other than set, the Man	17. Father's Name (First, Middle,	t's Education st grade completed)  College (1-4or 5+	(Give	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Disabled  18. Mother's Name (First, Middle, Main				N/A		
2 4 5 6	0	<del>_</del>	19b. Maili	ng Address (Stree		yn B. Bou	-	wn, State, Zip Code)		
permit Pages 1 and 2 should the Department of Health and Ment Important: If tem 27 is marked any njury or other traumatic once.	Evelyn B. Jone 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S 21. Signature of Funeral Service	3 □Removal from State Specify)	20b. Place of Dispo cemetery, crea Maryland	osition (Name of matory or other plants)  Nationa	1 9 ress of Facility	Date -16-2006 [arshall's	Laure Funera	eights, MD 2047 on-City or Town, State el, MD al Home ash. DC 20011		
Certificate be executed with the discrete as the burial-transit the search of the sear	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		ns of	ob e.	sitz		Approximate Interval Between Onset and Death		
ed by the attending pt detached for use as t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су		23d.	Date of delivery Month Day Year		
e ge	Part is, Other significant condition	ons contributing to death but	not resulting in the u	nderlying cause g	given in Part I.	1[	]Yes 2□N	contribute to the cause of death?		
ete has					OC Plane	pe 1 ☐ Yes	rformed? 2 No	tb. Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 ☐ No		
signal P	examiner?	Hospital:  1  Inpatient  28a. Date of Injury (Month, Day)	28b, Time o	f 28c. Inj	ther: 4 🗆 Nurs	9				
rs afte	)		y - At home, farm, sti (Specify)	reet, factory, office	9	28f. Location City or 1	(Street and Ni Town, State)	umber or Rural Route Number,		
the Furnible Formula Place of the Fu	(Check only one)  29 Certifier 1 Certifier (Check only one)  29 Medical one)	ng Physician: To the best of Examiner: On the basis of e and manner state	examination and/or in	vestigation, in my	opinion, death	place, and due to the occurred at the time	e, date and pla	ce, and due to the cause(s)		
င်နှာ် ငုံ့ နော် နောင်		J Bl 2		230. CIORI	40012	927	- 17			
9	30. Name and address of person	urbo and lotor and and	wh (he= 02=) 7	Permi	10057		71	Tember 15, 2009		

		For State Registrar	State of Ma		Department Certificate				iene g. No. 200	6 29515
Physic		1. Decedent's Name (First, Middle, La	KEI I S					2. Date of Deat Month		
/Medi Examir		4a. Facility Name (If not institution, give	nty ben		SA. C	dun	ation of Death  hip		4c. County of Dea	ath 9
Funeral Director		5. Social Security Number 6. S 218 32 6640 Usual Residence of Decedent	7. Age	70	Yrs. If Under Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Sep 13 1		irthplace (State or Foreign Country) yland
Maryland -f show	tor	10a. State 10b. County Md Howard		10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
death with the Maryland me 23e or 28e-1 show rmust be notified at	Funeral Director	10e. Street and Number 2256 Merion Pond			10f. Zip			10	0g. Citizen of What C	Country?
ğ 2 1	þ	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates: 1	0	13. Was Deceded If Yes, special 1 Yes 2		nic Origin? (Spe lexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036 ad within 72 hours af gjene. or than "natural, or t, the Medical Exerci-	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)			Decedent's Usual (Give kind of won life. DO NOT us Clerica	k done durin e retired)	g most of worki	ng	16b. Kind of Busines: Hotel Mana	•
Maryland 2 Maryland 2 to 2 should be filed the and Mental Hygi 27 is marked other traumatic event, 1	To Be Co	17. Father's Name (First, Middle, Last, Michael James			0.01.100	18.		Name (First, Middle, Maiden Sumame) Elizabeth Koehler		
9, Mary I and 2 show fealth and M im 27 is mar her traumati		19a. Informant's Name/Relationship ( Carolyn Kelly 20a. Method of Disposition	Турө, Print) wife	22	. Mailing Address  56 Merion Disposition (Name	n Pond	l Wood	dstock		163
altimore, mit. Pages 1 a partment of Hez portant: if item y injury or othe		1 Burial 2 Cremation 3 4 Dopation 5 Other (Special 21. Signature of Funeral Service, Lice)	y)	cemeter	ry, crematory or ot Carroll (	therplace) Cremat	ory Sep	13 2006		ld, Md
Balt permit. Departe import import		23a. Prit1 Inter the disease, or com	aung	the death. Do r	Winfie	ld, Ma	ryland	21784B		Funeral Home
Fnysician /Medical Examiner	er.	hock or heart failure. List only Immeriat. Cause (Final dislass of condition res. No. in death)  Sequentially list conditions, if any, leading to immediate	aDue to (or as a	e.  Inchi A  a consequence	of):		ue-	A Community and		Interval Between Onset and Death 2_ W &
Box 68760, death certificate be executed e attending physicien and id for use as the burial-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):					
, P.O. Box 60 that the death certific led by the attending pi detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the birth of the bir	2 Fetal death	3 □Ectopic pre 5 □ Other (spe				23d. Date of do Month	elivery Day Year
ecords, P law requires that as been signed t 2 should be det		Part II. Other significant conditions of	contributing to death bu	t not resulting in	n the underlying ca	ause given in	Part I.			to the cause of death?  Probably 4 X Unknown
d) a acu	Completed by	SIADH						24a. Was ar autops perform 1 \( \text{Yes} \) 2	y prior to	
of Vita Physicien: this certifica	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	nt 2□ER/Ou	tpatient 3☐ DO	Othor		Check only one	e) ince 6 □Other (Sp	
Sing ling After	Certification; T	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. 1	Fime of njury M	8c. Injury at Work? 1 ☐ Yes	2  No	28d. Describe ho	w injury occurred	
Divisic To the Hospital or Attency within 24 hours after desit To the Funeral Directors: completely filled in by the i		4 Homicide determined	building, etc	. (Specify)	rm, street, factory,			City or Town		
the Hos in 24 ho the Fun aptetely (	ledicai	(Check only 2 Medical Example)	nysician: To the best of miner: On the basis of and manner sta	examination an	d/or investigation,	in my opinio	n, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)
Mitt To Con	×	29b. Signature and title of partifier	17	mo		> Go4			Sep 12	
644			EMY YO.	sh'n	(Type, Print) 5755	Cens	~ LAUE	G	Sep 12 Jumpija	MD
Sta Regist		31. Date filed (Month, Day, Yeer) SEP 1 8	2006 32. Registre	r's Signature	Spale					
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State of Maryland /	Department of He	ealth and Mental	Hygiene	, 0

29516 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** :40 PM September 2006 Mary 6 Lewis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randall BALTIMORE Hospital Center stown Northwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 🕅 F Yrs Maryland Director 212-30-6895 05/08/1933 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "naturel", or items 23s or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Pikesville Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 7 Sudbrook Lane filed within 72 hours after deeth v Hygiene. yther then "naturel", or items 23s Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietary Worker 12 Hospital other permit. Pages 1 and 2 should be file Depertment of Health and Mentel Hy, Important: If tem 27 is marked othe ery injury or other treumstic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Virginia Lewis James Monroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9008 Wilbur Avenue, Randallstown, Maryland Ardella Lovelace / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/20/2006 4 □Donation 5 □ Other (Specify) Mt. Zion Cemetery Landsdowne, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple organ Tailure System /Medical Due to (or as a consequence of): **Examiner** inflammator stemic Donse syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rsicien and e burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed neumonia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical phys the t as attending p IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Periphera 1 Yes 2 No 3 Probably 4 Unknown vascular disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Peripheral neuropath Paneutopenia 1 Yes 25. Was calle refirred to med a examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury after death. Director: Af 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C completely filled i 1 Certifying Physician: To the best of my knowledge death consumed at the time date and blade and due to the naise(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28462 September Coolons 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Center Randallstown, Maryland Northwest 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar SEP 18 2006

		negistral		lental Hygie	ne2006 29517
Physicial /Medica Examine	n al er	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und Month.	y, Town, or Location of Death  A WAS II S TO W  1 Year I fl Under 24 Hrs.  5 Days Hours Min.	8. Date of Birth	Day Yeer 3. Time of Death  4c. County of Death  4c. County of Death  9. Birthplace (State or Foreign County Carry)  GERMANY
Director		Usual Residence of Decedent  10a. State  10b. County  MD  BALTIMORE  Months  10c. City, Town or Location  OWINGS MI		11/08/19	10d. Inside City Limits 1 Yes 2 No
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number  4500 CHAUCER WAY APT. 303  11. Marital Status  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Sive  1 □ Yes	tip Code  21117  edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto  2 No Specify:	ecify Yes or No-	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: WHITE
filed within 72 hours Hygiene. Sther then "natural; ent, the Medical Ext	Completed	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Us (Give kind of v life. DO NOT  SALES	vork done during most of work use retired)	ing	b. Kind of Business/Industry  INSURANCE  iden Sumame)
2 should be filed and Mental Hygi is marked other reumatic event,	To Be	LOUIS Lichtenauer  19a Informant's Name/Relationship (Type, Print)  19b. Mailing Addre	SELMA ss (Street and Number or Run DOW COURT - 01	al Route Number, C	LEVI ity or Town, State, Zip Code) LS. MD 21117
permit. Pages 1 and 1 bearming bear 1 and 1 bearment of Health Important: If Item 27 eny injury or other troops of the 1 bear 1 bear 1 bear 2 bear 1 bear 2		20a. Method of Disposition  1	chesed 09/1	5/2006 SOL LEVIN N ROAD -	RANDALLSTOWN, MD SON & BROS., INC. PIKESVILLE, MD 21208  Approximate Interval Between Onset and Death
be executed icien and burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
w requires that the death certilicate been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   No   Unknown   Unknown   Yes   Yes   No   Unknown   Unknown   Yes   Yes		= 4972	23d. Date of delivery Month Day Year
Be G	á	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknow
The la	Completed				24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
8 × 5	Certification: To Be	25. Was case referred to medical examiner?  1   Yes   20 No	Other: 4 Nursing Ho 28c. Injury at Work? 1 Yes 2 No	28d. Describe how 28f. Location (Stre	et and Number or Rural Route Number,
Hospi 4 hou Funer ely fill	edical Certif	29a. Certifier  (Check only one)	ed at the time, date and place,	City or Town, and due to the cau	State) se(s) and manner as stated.
To the To the To the To the Complet	Med		29c. License number  1143974	290 Six	Date signed (Month, Day, Year)  Atomber 14, 23,76
Stat Registra		31. Date filed (Month, Day, Year)  SED 1 8 2006  Registrar's Signature	ping way	19 MIJVV	in many wind

06-06904 Pearlie McGee

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State of Maryland / Department of Health and Mental Hygiene

	F	1- For State Registrar		ificate o				eg. No.	nn	6 295
Physicia I Examir		Decedent's Name (First, Middle,Last)     Pearlie		McGee			2. Date of Dea Month Septembe		ear	2354 hrs
- Admin		4a Facility Name (if not institution, give stre		Ticocc	4b. City, Town, or	Location of De		4c County	y of Death	
		Johns Hopkins Hospital			Baltimore				IA	
uneral irector		5. Social Security Number 6. Sex 216–36–4087 1X M	7. Age (In yrs las	st birthday) Yr	Months Day:		VI.	-1939	Foreig	hplace (State or n untry) N.C.
any	-	Usual Residence of Decedent  10a State 10b. County	10c. City, T	own or Loca	ation					10d. Inside City Limi
ntal Hygiene rked other than "natural", or items 23a or 28a-f show any ent. the Medical Examiner must be notified at once.	ě	Md. NA	!	Baltim						1 X Yes 2 N
r 28a- ed at	Director	10e. Street and Number			10f Zip Code 2121	2	1	0g Citizen of V USA		ntry?
items 23a or 28a-f sho ust be notified at once.		1818 E. North Ave.	. Was Decedent Ever in U.S.	. 13. W			( Specify Yes or No			can Indian, Black,
r items	Funeral	1 Never Married 2 Married	Armed Forces?  Yes 2 No		Yes, specify Cubar				ite, etc	
al". or	by F	3 Widowed 4 Divorced If Y	es, Give Year Dates:		Yes 2 X No				Black	
'natur Exam		15. Decedent's Education (Specify only h  Elementary/Secondary (0-12)	ighest grade completed)  College (1-4 or 5+)		nt's Usual Occupations of working life			16b. Kind of E	Business/I	ndustry
than this	Completed	12th grade	College (1-4 of 37)	Exa	miner			Monto	omer	y Wards
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Mental F marked c event. j	Be	James		McGee		Lill				
and M	٢	19a. Informant's Name/Relationship (Type, Noami McGee	Wife				or Rural Route Nui Baltimore		2121	
ment of Health and N tant: If item 27 is n or other traumatic	ŀ	20a Method of Disposition	20b. Pl	lace of Dispo	sition (Name of ce		Date	20c. Location	n - City or	Town, State
ent of I		1 Burial 2 Cremation 3 4 Donation 5 Other Specify.		ematory or o	em. Park		9-18-06	Randa	llst	on, Md.
Department of Heal Important: If item injury or other tra		21. Signature of Funeral Service Licensee	Creno Cr	22.	Name and Address	_	March F. Ave., Bal	H. East	Md.	21202
sician		23a Part I Enter the disease, or complicat failure. List only one cause on each li		Do not enter						Approximate Interv Between Onset an
edical iminer	ner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due	to (or as a consequence of) to (or as a consequence of)	:	sease					Death
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physician and he burial - transit	Medical	UNPENDED	MENDED							
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signed by the	by Phy	Part II. Other significant conditions con Chronic alcohol abuse	ntributing to death but not res	sulting in the	underlying cause	given in Part I.				the cause of death?
has been 2 should	Completed	Official algorital abuse					24a Was	an 24b	. Were au	ntopsy findings availab completion of cause of
certificate ector, page	S	25. Was case referred to medical			26 Place	e of Death (Ch	1	2 <b>V</b> No	1 Ye	es 2 No
is cert lirecto	Be (	examiner? Hosp	oital 1 Inpatient 2	ER/Outpatier		Othor:	ursing Home 5	Residence 6	Other	ri
fter th	ı: To	1 ✓ Yes 2 No 27. Manner of Death		28b Time of		ry at Work?	28d. Describe	how injury occu	ırred	
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ours after death eral Director: filled in by the	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor (Specify)	me, farm, str	eet, factory, office	building, etc	28f Location or Town,		nber or Ru	ral Route Number, Cr
within 24 hours To the Funeral completely filled	ledical C	one) 2 Medical Examiner: Or	To the best of my knowledge the basis of examination an	e, death occ nd/or investig	urred at the time, d	late and place, n, death occur	and due to the cau	se(s) and manr and place, and	er as star I due to th	ted le cause(s)
To con	Med	29b. Signature and title of certifier	d manner stated		29c. Licen:					nth, Day, Year)
1		Caliller	441		O.C.	M.E.		Septemb	er 13, 2	006
		30. Name and address of person who com			0		24204			
$\langle \cdot \mid$		I Zabiullah Ali, M.D. Assista	nt Medical Examiner	111 Pe	enn Street, Bal	timore, MD	21201			

DHMH 17 Rev 1/2001 OCME 2006

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Amy Elizabeth Martin State of Maryland / Department of Health and Mental Hygiene 2006 29519 1- For State Certificate of Death Reg No Registrar 1 Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner Month Day Year September 14, 2006 Elizabeth Amy Martin 1945 hrs 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Atlantic General Hospital Worcester Rerlin 5 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 219-31-6375 Days Months Hours Director -oreign **Mc**buntry) M 2X F 04 - 13 - 199115 Usual Residence of Deceden County 10c. City, Town or Location 10d. Inside City Limits any Howard Columbia 1 Yes 2 X No 28a-f show hours after death with the Maryland Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country 9007 Scotch Pine Court 21045 USA itenis 23a Funeral 11 Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 Married Yes 0 white Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify ş 15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) it Pages I and 2 shourd be arment of Health and Mental Hygiene arment of Health and Mental Hygiene overtant: If item 27 is marked other than "na armene went, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) student MD 21215-0036 education 10 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Douglas Richard Martin Be Jeanne Murphy 19a. Informant's Name/Relationship (Type, Print 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Martin (mother) 9007 Scotch Pine Ct., Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, 1 XBurial 2 Cremation 3 Removal from State Our Lady of Perpetual
| Help |
| 22. Name and Address of Facility permit Page
Department c
Important: Ellicott City, MD 9-20-06 Donation 5 Other Specify 21. Signature of Funeral Service Licens PO Box 195 Sykesville, Haight Funeral Home & Chapel, 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line Between Onset and /Medical a. Drowning Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last death certificate be executed and sician/Medical attending physician a UNPENDED AMENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? þ ₫. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 No After this certificate 1 V Yes Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be Other<sub>4</sub> Hospital: 1 Inpatient DOA Nursing Home 5 2 V ER/Outpatient 3 Residence 6 Other 1 V Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Sep 14, 2006 Naturai Drowned in ocean 1756 hrs 5 Pending 1 Yes 2 ✓ No hin 24 hours after death the Funeral Director: the 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Specify) Ocean 78th Street, Ocean City, MD Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E September 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month rar's Signature

State

Registrar

RELIE

2008

06-06945 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Douglas Martin 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Douglas Richard Martin 1905 hrs **Medical Examiner** September 14, 2006 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Deatl 4c County of Death Atlantic General Hospital Worcester Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** Min 266-81-8986 Months Davs Hours Feb. 2, 1962 Director 1 X<sub>M</sub> 2 Usual Residence of Decedent 10d Inside City Limits 10a State 10c. City, Town or Location 1 Yes 2 X No Columbia ( ) MD Howard 28a-f show or items 23a or 28a-f shomust he notified at once. ages 1 and 2 should be filed within 72 hours after death with the Maryland and of fleath and Mental Hygiene, 1. If then 21, 5 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 9007 Scotch Pine Court 21045 USA Funeral 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, Black 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes White Yes 2 No specify If Yes, Give Year Widowed Divorced Specify ş 16a Decedent's Usual Dccupation (Give kind of work done during most of working life DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Dept. of Defense Baltimore, MD 21215-0036 Computer Scientist 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) John Robert Martin Mary Jane Nairn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print ) Jeanne Martin (Spouse) 9007 Scotch Pine Ct., Columbia, MD 21045 20b Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: I injury or oth Our Lady of Perpetual Hello 9/20/2006 Ellicott City, MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signatury of Funeral Service Licensee PO Box 195 Sykesville,  $\propto \varphi$ Haight Funeral Home & Chapel, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a Drowning Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence or) events resulting in death) Last and Physician/Medical sician burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery phy the l 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify, Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? è Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? 1 V Yes this certificate ✓ Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other 2 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Sep 14, 2006 28b. Time of Injury After 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject drowned while swimming (caught by Natural 1756 hrs Yes 2 V No death 5 Pending Fo the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town State determined (Specify) Ocean 78th in Atlantic Ocean, Ocean City, Md. Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number 29d. Date signed (Month, Day, Year) 29b Su e and title of certif O.C.M.E. September 15, 2006 O Name and address of person who completed cause of death (Item 23a) 17 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

State

Registrar

rar's Signature

200

			For State Registrar	State of Marylar	nd / Depa <i>Ce</i> a	artment of H <i>rtificate of l</i>	ealth and N Death	Mental Hygid Reg	ene 2006	29521
	Physicia		1. Decedent's Name (First, Middle, La Rose Miller	ast)				2. Date of Death Month September	Day Year er 15 200	3. Time of Death 6 11:45 a M
	/Medic Examin		4a. Facility Name (If not institution, given 2400 Goldmine Ro			4b. City, Town, or Brookes	Location of Death		4c. County of Deat Montgomer	
	Funeral Director		104-36-7893	Sex 7. Age (In yrs 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y NOV . 16,	(ear) 9. Birt Co 1947 Aus	hplace (State or Foreign untry) tria
ī	ow ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	a-f eh	ctor	Maryland Montgo	omery		Brookevil	.le			1 ☐ Yes 2 ☑ No
	th with the 23e or 28	al Dire	10e. Street and Number 2400 Goldmine Ro	oad		10f. Zip Code	20833	100	g. Citizen of What Co USA	untry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene Item 27 is marked other then "natural", or iteme 23a or 28a-f ehow other traumatic event, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 27 No If Yes, Give 1 Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within 72 ho ene. then "natur he wedical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired & Buildin	during most of world ()	king	6b. Kind of Business/ Real Esta	
land 2	id be filed enta! Hygie ked other ic event, the	To Be Co	17. Father's Name (First, Middle, Las Jonathonr	Unterriener	1200		18. Mother's Nam	ne (First, Middle, Ma alena Rap	aiden Sumame)	
Maryland	l and 2 should k lealth and Ment im 27 is marked her traumatic e	٦	19a. Informant's Name/Relationship Jean-Claude Mil						City or Town, State, 2 MD 20833	Zip Code)
Baltimore,	permit. Pages 1 a Department of Hei Important: If Item any Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	cemetery, cre	osition (Name of matory or other plac y Cremati	e)		Sykesvi	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	Sonubl	P	.0. Box 1	<u>.95 Sykes</u>		21784 (41	
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.  a. Pan crea	tie	ter the mode of dyin		or respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to infinediate	b. One to (or as a conse						
oʻ	cate be executed physicien end the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
68760,		edical		d						
.O. Box	thet the deeth certificed by the attending (	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 th No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	The law requires thet the site has been signed by the bage 2 should be deteche	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause giv	en in Part I.		acco use contribute to	o the cause of death?
al Record		Completed						24a. Was an autopsy performe	ed? prior to death?	utopsy findings available completion of cause of
Vital	Physician: Tribis cartificate ral director, p.	o Be	25. Was case referred to medical examiner?  1 Tyes 2 The No	Hospital:	75000	oth Oth	or	th Check only one		
of	g Phys ar this ieral di	<b> -</b>	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o	nt 3 DOA	4 □ Nursing H	ome 5 Residen 28d. Describe how		city)
sion	Attending Fir death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigate	on	Injury		Yes 2 □ No			
Division	- = - c	Certification:	3 ☐ Suicide 6 ☐ Could not determine		home, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital of within 24 hours af To the Funeral D Sempletaly filled in	Medical	(Check filly 2 Medical Exa	Physician: To the best of my ke aminer: On the basis of examination and manner states.	www.deat	th occurred at the timestigation, in my o	pinion, death occu	rred at the time, dat	use(s) and manner as te and place, and due d. Date signed (Mghi	e to the cause(s)
	P MARKET ST		29b. Signature and title of certifier	WIR	-	Doc		-	0/11/-	L.
	10		30. Ne and address of person who				1335 ROC	PICCON KVILLE	mp	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 8	2006 Stewarts Sign	nature	Soule				

			For State Registrar	State of	f Marylan		artment <i>tificate</i>			nd Mer		ene g. Na-	006	2952	22
j.	Physicia	an	Decedent's Name (First, Middle, Last)  Page 1. Decedent's Name (First, Middle, Last)								Date of Deat	Day	Year	3. Time of De	ath M
	/Medic	al	Peggy Louise  4a. Facility Name (If not institution, give				4b. City, To	own, or L	ocation of I		ptembe	T-	2006 ounty of Death	9:20a	
	Examin	er	Carroll Hospital (				Westr	_				Car	roll		
5	Funeral		5. Social Security Number 6. Security Number 10	]м 2√2 F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Months		If Under 24 Hours		Date of Birth (Month, Day 1Ly 22 1	926	9. Birth Co. MD	nplace (State or F untry)	oreign
	Director		Usual Residence of Decedent	71								720	TID		
	larylan ahow	2	10a. State 10b. County Carroll			ty, Town or Lo Sykesvi								10d. Inside City I	
	28a-f	Director	10e. Street and Number				10f. Zip C	Code			11	g. Citize	n of What Co		Λ
	th with	ai D	2814 Lakeview Ave	nue			2178	84				USA			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic evant, it is Medical Francial must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1 ☐ Yes ff Yes, Giv Year or D	2 No		Was Decede f Yes, specif 1 ☐ Yes 2	y Cuban,	panic Origii Mexican, I Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)		. Race - Ame Bfack, White Decify: whi	e, etc.	
2-0	72 hou		15. Decedent's Edu (Specify only highest grad			(Give	dent's Usual kind of work	done du		of working		16b. Kind	of Business/	ndustry	
12	within ane. than "	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life. I	<i>po notu</i> se er cai	retired)	_	-		news	paper		
Baltimore, Maryland 21215-0036	id be filed ental Hygid ked other ic evant, I	To Be Co	17. Father's Name (First, Middle, Last) Raymond Cuts	sail		1		1		s Name (Fi	irst, Middle, M	Maiden Si	umame)		
ary	and Manaria	-	19a. Informant's Name/Relationship (Ty								oute Number			ip Code)	
დ 	t and the Health		Kenneth L. McQuay  20a. Method of Disposition	(son)	20b. I	2845 Place of Dispo			Ave.,	Syke	sville		21784 tion - City or	Town. State	
mor	ages ent of l nt: If it		1 DeBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from	State	cemetery, crer ke View	natory or oth	ner place)	L	-16-0			ville,		
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licens Gauge Hought	erbert		22	2. Name and	Address	of Facility	Haigh	-	ral	Home &	Chape1	
\$ gr	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on e	caused the dea each line.				_		spiratory arre	est,		Approximate Interval Betwee Onset and Dec	
· · · · · · · · · · · · · · · · · · ·	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to	(or as a consec	quence of):								7107FA	425°
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to	(ਹਾਂ ਬੜ ਕੇ ਹਮਾਤਦਰ	quence of).									
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.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	tcome of pregn birth 2 Feta nant at time of c own	af death 3	Ectopic pred Other (spec			<u> </u>		23	d. Date of del Month	very Day Yea	ar
<b>Q</b> .	Se 60	þ	Part fl. Dther significant conditions co	ntributing to d	eath but not res	sulting in the u	nderlying ca	use giver	in Part I.		23e. Did tol			the cause of dea	
Division of Vital Records,	The law ate has b page 2 sl	Completed							<u>-</u>	_	24a. Was a autops perform	y	prior to death?	itopsy findings av completion of cau 2   No	ailable se of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	-		heck only on				
on of	Phys r this ral dii	tion: To	27. Manner of Death Natural 5 Pending	28a. Date		28b. Time o Injury		Bc. Injury a Work?	4   Nurs	28d	5 🗌 Reside			cify)	
Divisi	is or Attending after death. I Diractor: Afte d in by the fune	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place build	e of Injury - At h ling, etc. (Speci	nome, farm, str ify)					Location (St City or Town		Number or Ru	ural Route Numbe	nr,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier Check only one) Certifying Phy	ner: On the b											
	To the h within 2. To the F	Me	29b. Signature and title of certifier	~ h	1.0			License		- )	2	9d. Date	signed (Mont	h, Day, Year)	
)	5		100	, ,		- 00-1 7	R	005	955	4			15/06	,	
	ę v		30. Name and address of person who c	ompreted caus	se or death (Ite	m 23a) (Туре, 9 <b>ххээ</b>	7001	9 1	POOLE	= RO	WEST	וצייונים	TEYZ M	D. 2/151	7
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 8 4	2006 32. F	Registrar's Sign	ature #	Sparke	,						D. 2/15",	

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

obert McNamar	1	For State Control of D		a Wichtai i	Reg	No. 2	106 2052
Physicia	n/	egistrar . Decedent's Name (First, Middle,Last)			2. Date of Death Month September	Day Year	1410 hrs
Medical Examir		Robert McNamara  4a Facility Name (if not institution, give street and number)  4b. (4b. (4b. (4b. (4b. (4b. (4b. (4b. (	City, Town, or	Location of Death		14, 2006 4c. County of	
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Funeral		5. Social decarity Hamber	f Under 1 Yea Months Day				9. Birthplace (State or Foreign Washington
Director		212-38-3333   1XM 2 F   66 Yrs.	Wioritris Day	s riours Will	June 23	, 1940	Country) DC
ny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d Inside City Limits
d how as		Maryland Prince George's Upper M	arlbor	0			1 Yes 2 X No
arylan 8a-f sl	Director	101/10110	Of. Zip Code		100	g. Citizen of Wha	t Country?
th the Maryland 23a or 28a-f show any notified at once.		5605 Green Landing Road	2077			United S	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed Forces? If Yes,		spanic Origin? ( S n, Mexican, Puerto		14. Race - White,	American Indian, Black, etc.
rer dea		1 X Yes 2 No	es 2 X No	specify:		Specify:	White
ours afi atural'	a b	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupa	tion (Give kind of b. DO NOT use ret	work done	16b. Kind of Bus	ness/Industry
s, MD 21215-0036 and 2 should be fifed within 72 hours after leath and Mental Hygiene tem 27 is marked other than "natural". traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				Solf-I	Employed
21215-0036 Juld be filed within 7 Mental Hygiene marked other than e event, the Medica	<b>E</b>	5+   Certifie	Tubi		e (First, Middle, Ma		Imployed
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- p # E E		Beverly M. McNamara/wife 7515 G1	eneagl	e Drive	Jessup,		1d ZU/94 City or Town, State
more, N Pages I and ent of Healtl int: If item		The section of the se	place)		15/2006	Odentor	n, Maryland
Baltimore, permit Pages I ar Department of Hes Important: If ite	-	4 Donation 5 Other Specify.	1.4.1.1.1.1	( = .:1)			
Baltir permit Departm Importa		Augusta Russamas) 1211	naldson Annap	Funeral olis Roa	Home & d Odent	on, Mary	y, P.A. land 21113
Physician		23a Fart I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying	, such as cardiac	or respiratory arres	st, shock, or hear	t Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  By Hypertensive Atherosclerotic Cardiov  Due to (or as a consequence of):	ascular Di	sease			Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
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876 tificate ng phy as the	M/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  2 IF Fetal Live birth 2 Fetal Fetal Feral Feral Fetal Feta	death 3	Ectopic pregr	nancy	Month	Day Year
of Vital Records, P.O. Box 6876(ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy tuneral director, page 2 should be detached for use as the b	Physician/	4 Pregnant at time of death 5 Othe	r (Specify)				
	Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause	given in Part I.	23e. Did to	pacco use contrib	oute to the cause of death?
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ian: 1	Be C	25. Was case referred to medical examiner?		Other <sub>4</sub> Nurs			
F Vit Physic or this cral dire	10 E	examiner / 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27 Manner of Death 28a Date of Injury 28b Time of Injury		ury at Work?		Residence 6	
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ivisior  Or Attend  after death  Director:	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street,	factory, office	building, etc.	28f. Location (S or Town, St		er or Rural Route Number, City
Div ospital o hours af meral D	Certification:	4 Homicide determined (Specify)			<u> </u>		
₹ ₹ E le	cal (	29a Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurre one)  Medical Examiner: On the basis of examination and/or investigatio	ed at the time, on, in my opinio	date and place, a on, death occurred	nd due to the cause t at the time, date a	e(s) and manner and place, and d	as started ue to the cause(s)
To the within To the comple	Medical	and manner stated  29b Signature and title of certifier		nse number			ed (Month, Day, Year)
		( lay se Hallan	0.0	C.M.E.		September	15, 2006
NA NA		30 Name and address of person who completed cause of death (Item 23a)					-
1/1		Outer / many many	treet, Baltir	more, MD 212 			
S Regis	tate strar		edi				

Decedent's Name (Free Middle, Last)   Decedent's Name (Free Middle, Malere) Name (Free Middle, Last)   Decedent's Name (Free Middle, Malere) Name (Free M			·	For Stete Registrar	State of Maryla		ent of Health and ate of Death	Mental Hygier		29324
A Facility Name (Prior standard by Prior stand		Physicia	án	1. Decedent's Name (First, Middle, Las	- 111	1 M-	7		Day Year	3. Time of Death
Formical Director   Social South Name   Co. Social Social Name   Co. Social Name   Co. Social Name   Co. Social Social N		/Medic	al		1	4b. Ci	ty, Town, or Location of Dea	th JEVIS	2 COC 4c. County of Death	(c 130 "
Control   Cont			•	108 HIGH		CT; 1	ON DALL	9 Date of Righ	BALTO.	CO.
100. County				Will and miner		// Month		Month, Day, Yea	19/9 S. Billing	ntry) MD :
Elementary/Reportary (0-12)   College (1-for 5+)   Iffe. ONO for use nature)   Colle		land w			10c.	City, Town or Location				10d. Inside City Limits
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Elementary/Reportary (0-12)   College (1-for 5+)   Iffe. ONO for use nature)   Colle	036	urs afte	þ		1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		. /		Specify: 112	HITE
15. Mailing Addgrass (Street and Number or Rural Route Number. City or Town, State 20.000 (J. F. Faharris Name (First, Middles, Machine ) (First, Middles, Machine) (First, Middles, Machine) (J. Faharris Name (First, Middles, Machine) (J. Fa	2-0	-	leted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give kind of	work done during most of wo	orking 16b	. Kind of Business/In	dustry
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Physician  Medical Examiner  Physician  Medical Examiner  The disase of conditions as a consequence of):  Sequentially list conditions, any, leading to mendate cause (right) of the cause of the past 12 months?  In FEMALE:  23b. Hys., doing to find the past 12 months?  In FEMALE:  23b. Was decedent pregnant in the past 12 months?  In Physician  The past 12 months?  In FEMALE:  23b. Was decedent pregnant in the past 12 months?  In Physician  The past 12 months?  In Phy	aryl	should and Me mark umatic	Ţ	19a. Informant's Name/Relationship			ess (Street and Number or R	ural Route Number, Cit	ty or Town, State, Zij	Code) 21236
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Physician  Medical Examiner  Physician  Medical Examiner  The disase of conditions as a consequence of):  Sequentially list conditions, any, leading to mendate cause (right) of the cause of the past 12 months?  In FEMALE:  23b. Hys., doing to find the past 12 months?  In FEMALE:  23b. Was decedent pregnant in the past 12 months?  In Physician  The past 12 months?  In FEMALE:  23b. Was decedent pregnant in the past 12 months?  In Physician  The past 12 months?  In Phy	3alti	ermit. I separtm nportai ny injui			7	22. Name	and Address of Facility	2829 H	UDSER	37
Physician (Medical Examiner   Medical Examiner		202 • a		23a. Part1. Enter the disease, or com-	plications that caused the d	leath. Do not enter the m	node of dying, such as cardia	BALTO, ac or respiratory arrest,	142:21	Approximate
Due to (or as a consequence of):    Due to (or as a consequence of):		Physician		Immediate Cause (Final disease or condition	one cause offeach line.	in son's	O, sease			Onset and Death
The property of the property o				resulting in death)	Due to (or as a cons	sequence of):				
Space   Spac	D	D #	ner	cause. Enter Underlying		sequence of):				
Space   Spac	•	al-trans	xam	that initiated events	cDue to (or as a cons	sequence of):				
FFEMALE: 29b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknow	3760	ate be hysicienthe buri	lical	(	d	····				
Solution of the control of the contr	_	certific nding p use as i	√/Mec						23d. Date of deliv	ery
Solution of the control of the contr	S. Bo	e death he atter	siclar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of					
Part		that the		Box II Other significant conditions o	gntributing to death but not	resulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute to 1	he cause of death?
Part	ords	equires sen sigr ould be	ted b	_ Cerchauseus	u to 4 dest	· · · · · · · · · · · · · · · · · · ·		1 Tes	2₽No 3□Prol	bably 4 Unknown
The property of the property	Reco	has be	mple	Mypertens	ion			autopsy	prior to co	impletion of cause of
The property of the property	ital	ien: Th	0				26. Place of De		No 1 □ Yes	2 10
The property of the property	of <	Physic this ce	၉	1 ☐ Yes 2 ☐ NO	1 Unpatient 2		DOX 4 INUISING			fy)
3 Suicide 4 Homicide  4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	ion	ath. r: After	atlon	1 Natural 5 ☐ Pending				200. Describe now in	ijary occurred	
29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Sivis	or Atterde Directo	rtific	dataminad	286. Place of Injury - A		tory, office			al Route Number,
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	_	bours and hours		29a. Certifier 1 Certifying Ph	lysicien: To the best of my	knowledge, death occurr	ed at the time, date and place	e, and due to the cause	e(s) and manner as :	stated.
1 100 HAMMICZE 9/14/116		thin 24 thin 24 the Formplete	Medi	one)	and manner stated.					
- INVUDITA IN THE THE		F 3 F 8		>//	- 6-	100	1400616	38	9/14/06	
5 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)  2801 HMdSON St., Syite A Baltman, 402 (224)	6	1		39. Name and address of person who		(Item 23a) (Type, Print)	10 A R	1+ Dans	400	174
State 31 Date filed (Month, Day, Year) 32 Segistrar's Signature SFP 1 8 2006 Section 18					32. egistrar's Si	ignature Social	117 11 139	TIMINT /	-10 21	w d 1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 29525 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day September 8, **Physician** 2006 1:30 PM M Margaret C. MacLuckie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air 10 Colonial Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 💢 F 89 Apr 17, 1917 Maryland 234-44-1602 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location wode Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Bel Air MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 10 Colonial Road USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 le marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 12 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William MacLuckie Agnes Robertson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.:
Department of Heelth ar
Important: If Item 27 1e
any Injury or other trau 25501 Jarl Drive RT2 Gaithersburg, MD Ernest Screen/cousin Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 □ Other (Specify) 21. Signature of Funeral Services State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MĎ nn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congrut dans Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. this certificate has been signed by the attending physician at director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 Division of Vital Records, Syndrame 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ٥ funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? After t or Attending 1 Natural 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funerel D completely filled i the Hospitel 1 Contitying Physician: To the best of my knowledge death occurred at the time. Tat, and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of 1 ath (Item 23a) (Type, Print) le St. Balto md 21208 N. Ch 4 unc 6701 Registrar's Signature 31. Date filed (Month, Day, Year) 32. State 2006 6 Registrar

			1 - For Amend #5 Per FH	State of Mary G859 9/22	vland / Depa 2/06 J⊮Eer	artment of H	lealth and M Death	lental Hygie	ene a. No. 2006	29526
1	Physici	an	Decedent's Name (First, Middle, Last)     IRMA		MORGEN			Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give str	eet and number)	11011012.1		r Location of Death	Septembel	4c. County of Dea	
	LAGIIIII		Greater Baltimore M			Towson			Baltimore	2
	Funeral Director		E00 EE 1011	4 00 5	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 01/22/19	9. Bir	thplace (State or Foreign ountry) RHODE ISLAND
	land ow		Usuaf Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Marylan e-f ehow	ctor	MD BALTIMORE		BALTIM	ORE				1 ☐ Yes 2X☐ No
d	th with the ME 23a or 28e-f	ai Director	10e. Street and Number 817 HOPEWOOD ROAD			10f. Zip Code 21208	3	10	g. Citizen of What C	
2	I Z I 3-UU30 within 72 hours after death with the Maryland ene. then 'natural', or items 23e or 28e-f ehow item 'natural', or items 23e or 28e-f ehow in Maries Examination at the material and at the materia	by Funeral	1 ☐ Never Married 2 🕅 Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
17 8	72 hours "natural",	ted b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Education		16a. Dece	dent's Usuaf Occup	ation	11	6b. Kind of Business	
	d within 73 yiene.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of worki d) SPECIAL		TATE DEPAR	RTMENT
9	ing, Marylatin ZIZID-0030 s 1 and 2 should be filed within 72 hours alt f Health and Mental Hygene. Item 27 is marked other then "natural", or other traumatic event, the Mudical Exa.	To Be C	17. Father's Name (First, Middle, Last) DAVID		SCHNEID	ER	18. Mother's Name	e (First, Middle, M	aiden Sumame)	PARIS
5	Mary nd 2 shou lith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type MANFRED MORGENTHAU			•			City or Town, State, MD 21208	
et	Dattimore, Mispermit. Peges 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tray 20ce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re-		20b. Place of Dispo		ce)	Date 2	Oc. Location - City or	Town, State
	Datumor  Demit. Peges Department of the mportant: if its only injury or o		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	QI	HEB SHALO	M MEMORIA  Name and Addres			REISTERST(	
8	Depa Impo		Rollo	Z	$\supset$	900 REIS	TERSTOWN	ROAD - P	ON & BROS. IKESVILLE	MD 21208
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	itions that caused the cause on each line.	adeath. Do not ent	er the mode of dyin	-	or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a co	onsequence of):					
9	BOX BOY BU, eath certificate be executed attending physicien and for use as the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
g	rtificate ng phy:	Aedic	IF FEMALE:							
	hat the death certification by the attending processes detached for use as	/sician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other <i>(specify)</i>	/		23d. Date of de Month	olivery Day Year
6	COFGS, P.O. W requires that the search signed by should be detact.	d by Ph	Part fl. Other significent conditions control Cav	, ,	ot resulting in the u	nderlying cause giv	en in Part I.			o the cause of death?
	INVISION OF VITAL RECORDS, P.O. BOX OF I or Attending Physician: The law requires that the death certific at after death.  Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me						24a. Was an autopsy perform	ed?   death?	utopsy findings available completion of cause of
1	VICIAN: This certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one		-
	OT V Physic this ce	ပ	1 Yes 2 No Ho	spital: 1 Inpatient	2 ER/Outpatier		4   Nursing no	me 5 Resider 28d. Describe hov	nce 6 Other (Spe	ecify)
1	nding I nth. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	Wor	k? Yes 2 □ No	284. 26361106 1104	williary occurred	
	DIVISIO  Jor Attendi  atter death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	- At home, farm, str Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
	LIVISION OF VICAL Report To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medicai C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the best of m er: On the basis of ex and manner stated	amination and/or in	h occurred at the tir vestigation, in my o	me, date and place, opinion, death occurr	and due to the car red at the time, dar	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		1	29c. Licens			d. Date signed (Mon	
	27		→ Gunthur Sm 30. Name and address of person who con	npleted cause of deat		Print)	03154	/	9/11/0	4
	10		Cyuthia Soriand	MD 670,		ivles St.	Baltin	none i	102120	<i>y</i>
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  SEP 1 8 2006	32. Registrar's		all I				

### 06-06881 Irene Matthews

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State	Certifica	ate of	Death			Reg	j. No.	200	6	2952
Physicia	n/	Decedent's Name (First, Middle,Last)						ate of Death onth ptember	Day	Year	3 Tim	e of Death 57 hrs
Medical Examin		Irene Matthews  4a. Facility Name (if not institution, give stre			b City, Town, o	r Location o		ptember		unty of Death		
		Northwest Hospital	set and humbery		Randallsto					more Cou		
Funeral		5. Social Security Number 6 Sex	7. Age (In yrs last birti	hday)	If Under 1 Ye	_		Date of Birth	(MM/DD/	YYYY) 9 Bır Foreig		(State or
Director		215-13-7304 <sub>1 M</sub>	2X <sub>F</sub> 19	Yrs.	Months Da	ys Hours	Min. 11	L/13/	86		untry)	MD
	- н	Usual Residence of Decedent	10c. City, Town	or Locati							10d Ir	nside City Limits
ow aff	-	10a State 10b. County  MD Baltimor										Yes 2 X No
Maryland 28a-f show any <u>d at once.</u>	핡	10e. Street and Number	.c wood	Lawi	10f Zip Code			109	g. Citızen	of What Cou		
th the Maryland 23a or 28a-f sho notified at once.	Director	2621 West Park D	rivo		21	207			US	٠,٨		
hours after death with the Maryland "natural", or items 23a or 28a-f sh Examiner must be notified at once	声	11. Marital Status 12	. Was Decedent Ever in U.S.		s Decedent of H	ispanic Orig			14.	Race - Amer White, etc.	ican Ind	ian, Black,
death or iten must l	Funeral	1 X Never Married 2 Married 1	Armed Forces? Yes 2 X No		es, specify Cuba		, Puerto Ricar	1, etc.)		Afi	cica	an-
after ral",	ᇍ	3 Widowed 4 Divorced If Y	Dates:		Yes 2 X N		kind of work o	lono	Spe	of Business/	eric	can
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify only h  Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working lif			10110			Í	
136 thin 77	ad l	2	2	Stu	dent				Со	llege	5	
		17 Father's Name (First, Middle, Last)					's Name (Firs					
2121 ould be fi Mental marked c event,	o Be	Elmer J. Matthew  19a Informant's Name/Relationship (Type,	s Jr.	n Mailine	Address (Stre	Lav	rerne	M. P	ende	rgras	SS	odo)
	티	Laverne M. Pende										l l
	ŀ	20a. Method of Disposition				emetery,	Dat	e W	20c. Loca	ation - City or	Town,	21207 State
Baltimore, permit Pages I an Department of Hea Important: If iter		1 X Burial 2 Cremation 3 4 Donatron 5 Other Specify:	Removal from State Cremat	Zic	ner place)		9/16/	06	Lans	downe	, N	1D
Baltimo permit Page Department of Important: injury or oth		21. Sive one of Fu Service	101	22. N	ame and Addre	ss of Facility	Wylie	F/H	P.A	. of	Ва	lto. Co
	4	23 Far Entrithe disease, or complete	16	920	00 Libe	erty	Rd.,	Rand	<u>alls</u>	town,	MI	21133
Physician /Medical	A	23 Far Ent r the disease, or control of future. List only one cause on with I	ine	ot enter th	ne mode of dying	g, such as c	ardiac or resp	oratory arre	st, snock,	or neart	Bety	ween Onset and Death
Examiner		m mediate Cause (Final disease a. or condition resulting in death)	Pheochromocytoma to (or as a consequence of):								-	Death
		Sequentially list conditions, b.	to (or as a somsequence or).									
	ner	if any, leading to immediate Due cause Enter Underlying Cause	to (or as a consequence of);									
	Examine	(Disease or injury that initiated C.	to (or as a consequence of):									
ecuted and transi		d									+	
O, e be executed ysician and burial - transi	/Medical	A	MENDED item#23a,27,		,g860, 10	)/12/06	TT					
3760, ificate be g physical sthe buri		23b Was decedent pregnant in the	23c. If yes, outcome of pregnancy  Live birth	p Fe	tal death 3	Ectopie	c pregnancy			ate of deliver nth	y Day	Year
ox 68' eath certifi attending for use as	icia	past 12 months?			her (Specify)							
cords, P.O. Box 68 aw requires that the death certif nas been signed by the attending 2 should be detached for use as	Physiciar	Part II. Other significant conditions co	Unknown	a in the i	indarlying cause	a given in Pr	art I	23e Did tol	nacco use	contribute to	the car	ise of death?
P.O.	β	Part II. Other Significant conditions (co	minbuting to death but not resulting	ig in the t	anderlying cause	e given iin i	art i					4 🗸 Unknown
ds, ladines	Completed						_ {	24a Was a				indings available
cords law requi	nple		<del>-</del>				<del></del>	autops	med?	death?		on of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical	_		26.Pla	ce of Death	(Check only	1 Yes 2	2 No	1 🗸 Y	es	2 No
Vital hysician hysician this cert	Be	examiner?  1 ✓ Yes 2 No	oital: 1 / Inpatient 2 ER/C	utpatient		Other;	Nursing Ho		Residence	6 Othe	er.	
Division of Vital Records, P.O. Box 68 tal or Attending Physician: The law requires that the death certif its after death.  al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b.	Time of	Injury 28c. In	ijury at Work	k? 28d	. Describe h	ow injury	occurred		
ion ttendir leath. tor: /	Certification:	1 X Natural 5 Pending 2 Accident Investigation			1_	Yes 2	-					
IVIS For At after d Direc	tific	3 Suicide 6 Could not be	28e. Place of Injury - At home, f	arm, stre	et, factory, office	e building, e	tc. 2Bf	Location (S or Town, St		Number or R	ural Rou	ute Number, City
D sspital hours meral		4 Homicide determined  29a. Certifier 1 Certifying Physician:	(Specify)	-41		d-t		4- 4b			et o el	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director.	Medical	one) 2 Medical Examiner: On	To the best of my knowledge, denote the basis of examination and/or									e(s)
To To com	Med	29b Signature and title of certifier	d manner stated		29c Lice	nse number			29d Date	e signed (Mi	onth, Da	ıy, Year)
A.	1	In west Frenchall	inin —		0.0	C.M.E.			Septer	mber 12, :	2006	
- W		30 Name and so of person to com	ppleted cause of death (Item 23a)									
11	u 25		stant Medical Examiner	111 F	Penn Street,	Baltimor	re, MD 212	201				
	ate	31. Date filed (Month, Day, Year)	32. Regulara's Signature	1 6	berle							
Regis	ueli	Ohn the Ohn	1	500								

			1 - For State Registrar	State of Marylan		artment rtificate			nd M		iene 19. No. 2	006	29	528
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)     NICOLE NAT     4a. Facility Name (If not institution, give s	treet and number)		4b. City, T	'own, or l	Location of	Death	2. Date of Death Month	Day 5	Year 06 ty of Death	3. Time of 11:45	Ам
	Funeral Director		00-21-5510			If Under 1	Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, 9 - 7 -	PRINC Year) 79		EORGE place (State on try)	
	hours after deeth with the Maryland tural, or iteme 23a or 28e-f ehow al Examinar must be motified at	Director	Usual Residence of Decedent  10a. State  10b. County  MD  10e. Street and Number	1-01-1	y, Town or Lo		RLB	oro			og. Citizen of		0d. Inside Ci	•
	r deeth with the Marylan eme 23a or 28e-f ehow er must be notified at	Funeral Dir	1400 DOEWOOD	LANE  12. Was Decedent Ever in U. Armed Forces?	.S. 13. \	20	172	panic Orig Mexican	in? (Spe	cify Yes or No-	14. Ra	SA ace - Americack, White,	an Indian,	
21215-0036	72 hours afte natural', or it alcal Examin	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	16a. Deced	1 ☐ Yes 2	No Occupat	Specify:		unk		ity: BLA	CK	unk
	filed within 7 Hygiene. other then "r ent, the Med	e Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	un	retired)			(First, Middle, N	faiden Suma	me)		unk
Maryland	12 should be h and Mental 7 ie marked c traumatic ev	To Be	19a. Informant's Name/Relationship (Typ.		1					Route Number,	,		Code)	
Baltimore, I	Pages 1 and nent of Heelti int: if item 21 iry or other i		Prince George's Ho  20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. P	C 3001 Place of Dispo	sition (Name	e of		-		MD 207		own, State	
Balti	permit. Depertu importa eny inju		21 Signature of Funeral Service Lie ose	ade, rector	Ba	ltimo	re,	MD 2	1201			ore S	treet	
	Pnysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	DIAC			HM12		respiratory arre	si,	,	Interval Bet Onset and I	ween Death
	Examiner pushing particular properties and properti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	RESPIRATORY Due to (or as a consequence of the cons	uence of):	LURE						/	O DAY.	
68760,	icate be executed physicien and s the burial-transit	cai	resulting in death) Last	Due to (or as a consequence of the consequence of t		NODEF	ICIE	ENCY	5)	NDROME			EARS	
P.O. Box (	The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as it	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	Ideath 3□	Ectopic pre Other (spe						ate of delive		∕ear
Records, P	w requires that the de been signed by the e should be detached f	þ	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying ca	use giver	n in Part I.			acco use cor s 2∭No		ne cause of d ably 4 □l	
tal Rec		e Completed	25. Was case referred to medical					os Bless	of Dooth	24a. Was ar autopsy perform 1 Yes 2	ed? X No	prior to con death?	psy findings and post of care and post o	available ause of
Division of Vital	ding Phys h. After this funeral dir	atlon; To Be	examiner?  1 Yes 2 No Hi  27. Manner of Death 1 Notural 5 Pending investigation	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Cther c. Injury : Work?	4 🗆 Nur	sing Hom	ne 5 Resider	nce 6 Ot		/)	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Il Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	v)					8f. Location (Str City or Town	State)			ber,
	To the Hoe within 24 he To the Fun completely	Medical	(Check only 2 Medical Examination)  29b. Signature and title of celtifier	ician: To the best of my kno ler: On the basis of examina and manner stated.	tion and/or inv	vestigation, i	n my opi	nion, death number	occurre	d at the time, da	te and place	, and due to	the cause(s	)
,			30. Name and address of person who could ATUL Sull, MD	2-11	16-0-	Print)	00 6 X	282	CHE.	VERLY, 1	9-	0185	9	
	Sta Registi		31. Date filed (Month, Day, Year)  SFP 1 6 2	32. Registrar's Signa	ture	porti				, , , ,	·	, , , ,		

Amen item#23d, PLI, 25, pen/E, 880, 10/12/00 II of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
Registrar

1- Reg. No. 2006 29529 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:35p Physician 2006 harles LRC rept /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Nursing Cevindale Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** 1 M 2□ F Months 239-52-8919 Usual Residence of Decedent Jan Director 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it is Marcical Examination in 1988. 1 ☐ Yes 2 No Ma Baltimore Funeral Director atonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 ase 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 █ No Maryland 21215-0036 Specify. Specify: Black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) echanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Perry -0 434 James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a, Informant's Name/Relationship (Type, Print) P210 10 21215 Beehles 3809 Baltimore allie HUR Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 116/06 Lansdowne 2ioN 4 ☐Donation 5 ☐ Other (Specify) - Harris FUNZ Cal Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility hatman nd Baltimore Md 21215 5240 Relaverstown 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) dons **Physician** /Medical Due to (or as a consequence of) aucular Disease Examiner pheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner ATION APPROVED BY MEDICAL EXAMINER attending physician and of for use as the burial-transit bure inte The law requires that the death certificate be executed to (or as a consequence of) P.O. Box 68760, Complications of Diabetes Mellitus Physician/Medical CERT IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day signed by the atter in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II ģ Records, 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy riscare 1 TYes Vital 25. Was case referred to medical examiner?

1 X Yes 2 00 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 1 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical tive of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and and address of person who completed deuse of death (Item 23a) (Type, Print) San 2. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 8 2006

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

			For	State of Marylan		ent of Health and I	Mental Hyg	iene 200	6 29531
			Registrer		Certific	ate of Death		ig. No.	
	Physicia	an	Decedent's Name (First, Middle, Last	S. Ran	1.10/		2. Date of Deat Month	Day Year	- / 6 · 3 - 0M
1	/Medic		4a. Facility Name (If not institution, give			ity, Town, or Location of Death	Sept	14 200 4c. County of De	
1	Examin	er	Ilnion Memor	. 1 11	P	altimore		NILA	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In) rs.	Mont	nder 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9, B	irthplace (State or Foreign Country)
	Director		1-18-2814	M 2□F S2	Yrs.	ns bays nous win.	5-30	1924 M	aryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Manyl f sho	ō	LA notA	Bo	altimor				1 446s 2 □ No
	r 28a	rec	10e. Street and Number		10f.	Zip Code	1	Og. Citizen of What (	Country?
	deeth with the Maryland ma 23a or 28a-f show rmat be notified at	Funeral Director	27 7. Gorm	an Ave		21223		u.s.	A
	tems tems	nuel	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Do	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	rs afte	by F	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 <b>27</b> es 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Ye	s 2 No Specify:		Specify: 13	lack
21215-0036	72 hours after natural', or ite dical Examina		15. Decedent's Edu	ucation	16a. Decedent's		4:	16b. Kind of Busines	is/Industry
215	within 7. lene. then "n	Completed	(Specify only highest grad	College (1-4or 5+)	ife. DO NO	work done during most of wor Tuse retired	king	- 1	i
	filed wi Hygien ther th	Co	12		Cran			5+	Le
and	ntal H od otl	Be	17. Father's Name (First, Middle, Last)			E.I.	ne (First, Middle, M		
Maryland	2 should the and Ment is marked aumatic	မ	19a. Informant's Name/Relationship (T		19b. Mailing Add	re (Street and Number or Ru	ral Route Number		Zip Code) 21216
Z	라를 C 라		Carrie Rails	Inh Wife	1011	Poplar Cri	ve St.	Bolt	o. hel.
ore,	a 0 _ L		20a. Method of Disposition  1 Burial 2 Cremation 3	1 7	lace of Disposition cemetery, crematory	Name of or other plage)	Date	20c. Location - City of	or Town, State
altimore	Pages ment of ent: If It		4 Donation 5 Other (Specify,		consuille	Vet Cem 19-2	1-2006	Jana Aru	inde led.
Ball	permit. Page Department Importent: It any Injury or once.		21. Signature of Funeral Service Licens	1	Nam	e and Address AFacilin	الم عدمات	uneral	service PA
	adrea.		23a. Part1. Enter the disease, or comp	lications that caused the deal	b. Do not enter the	mode of dving such as cardiac	or respiratory arre	CLITO. N	Approximate
	Dhamisis		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each toe.	. 1 000	J			Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. YOUS UTOLSO	uence of):	- juneum	acuraci	al Cinema	3 months
	Examiner		Sequentially list conditions	Mpper o	postroir	testinal 1	fled		1 day
	B 1/2 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conseq	uence of):				J
	secution of the secution of th	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):				
8760	cate be executed physicien and the burial-transit	lical E		d					
9	tificati ng phy as the	ledic		<u>.</u>					
Вох	death certifical e attending phy ed for use as th	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		ic pregnancy		23d. Date of d	delivery Day Year
	ne dea the at hed fo	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of d 9□Unknown	leath 5 Other	(specify)		Month	Day 18a:
P.0.	that the de ed by the detached		Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlyi	ng cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
of Vital Records,	law requires that the es been signed by th 2 should be detache	d by			,		1 □ Y€	s 2 No 3	Probably 4 Tunknown
Ö	aw req ss beer 2 shou	Completed					24a. Was a		autopsy findings available
Re	o ~ o	HO.					autops perform	y prior t ned? death ! ☑ No 1 ☐ Ye	
ita	ysicien: Th is certificete director, pag	BeC	25. Was case referred to medical examiner?				th (Check only on	9)	
کر در	© 2 €	မ	1 Yes 2 No			DOA Other: 4 Nursing H			pecify)
u C	Jing F	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Division	it or Attending effer death. I Director: After d in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, fa				Rural Route Number,
ă	s effer s effer il Dire	Certification:	4 Homicide	building, etc. (Specif	<b>(y</b> )		City or Towr	, State)	
	To the Hospitat or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical (	(Check only 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina	owledge, death occu	rred at the time, date and place	, and due to the ca	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2. To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	2	9d. Date signed (Mo	nth, Day, Year)
	F 3 F 8		B. P. Dave	M.D.				-	
	3		20 Name and address of parson who s	completed cause of death (Iter	n 23a) (Type, Print)	AT24389	.0	70 17	1
			BIJAL P.	DAVE, U	NION	MEMORIAL	- HOSP-	ETAL, 1	YD.
	Sta Registi		31. Date filed (Month, Day_Year)	DAVE U 32. Registrar's Signa	ature Los	Be)		,	
	riegisti	ui	CED 1 8 7	UUb DEREUS	M. R.	Bridge.			

			1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of F rtificate of	Health and IV <i>Death</i>		lene2006	29532
	Physici /Medic		1 Decedestic Name (First Middle Lee	T R	ODRIGO	UES		2. Date of Death		3. Time of Death
	Examir		4a. Facility Name (If not institution, give				or Location of Death		4c. County of De	ath
	Funeral		North Hampton Mano 5. Social Security Number 6. Se	r Health C	are ge (In yrs. last birthday) Yrs.	Freder If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Freder	rick inthplace (State or Foreign Country)
	Director		212 36 5739 Usual Residence of Decedent	X	71			Feb 1 1	935 Mar	ryland
	yland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	Director	Md Carro	11	Mt. Air					1 □ Yes 2 □ No
	with the	Dire	10e. Street and Number	7		10f. Zip Code		10	og. Citizen of What (	Country?
	Jeath Trues	erai	207 Frederick	12. Was Decedent	Ever in U.S. 13.		1771 Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	US 14. Race - Arr	nerican Indian,
5-0036	be filed within 72 hours after death with the Maryland hal Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Madical Exanti arrinal be indified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 □ Yes 2 □ If Yes, Give → Year or Dates:	No	If Yes, specify Cub 1 ☐ Yes 2 ★ No		Rican, etc.)	Black, Wh	nite, etc. White
5-0	72 hc "natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occup	pation during most of work d)	ing	16b. Kind of Busines	s/Industry
2121	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or	5+) Homer		od)		orm hama	
	Hygi other	0	17. Father's Name (First, Middle, Last)		IIOREI	lianer	18. Mother's Name	e (First, Middle, N	OWN home faiden Sumame)	
Maryland	should nd Mer marka marka	ToB	Norman 19a. Informant's Name/Relationship (7)	E iype, Print)	Etzler 19b. Mailir	ng Address (Street	Dorothy and Number or Run	. Ral Route Number,	City or Town, State,	herts Zip Code)
	1 and 2 Health a tem 27 le		Norma Lee Dennis	Sist	er 800	5 Parade	Lane Mt.	Airy M	d 21771	
Baltimore,	8 2 ≥ 5		20a. Method of Disposition 1 3 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei				c. Location - City of	
Ē	nit. Pa antmen ontant: injury		4 ☐ Donation 5 ☐ Other (Specify,  21. Signature of Funeral Service License	)	Arlington				rlington een Funer	Virginia
Ba	permit. Departr Imports eny inji		Vall.	alle	12	212 W. Ol	d Liberty	kd Winf	ield Md	21784
	Physician /Medical Examiner	0.000	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	ne.	O CALL	1. 1 -	or respiratory arre	retion	Approximate Interval Between Onset and Death
3-	1 A. A.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):					
_	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
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	tificate ng phy as the	<b>l</b> edicai		<b>.</b>						
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant <i>a</i> 9 □ Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
٥	uires that the signed by Id be detacted	ρ	Part II. Other significant conditions co	entributing to death b	out not resulting in the u	nderlying cause gr	ven in Part I.			to the cause of death?  Probably 4 Dunknown
Records,	The law require ate has been signage 2 should b	Completed						24a. Was ar autopsy	prior to death?	autopsy findings available ocompletion of cause of
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h Check only one		is 2   NO
of V	Physic this ce al direc	To	10 105 2000	Hospital: 1 🗌 Inpati		1 3L DOA		me 5 Reside	nce 6 □Other (Sp	necify)
o uc	ding P h. After t funera	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ary Year) 28b. Time o	Wo		28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, farm, str cc. (Specify)		]Yes 2 No	28f. Location (Str City or Town	eet and Number or I , State)	Rural Route Number,
_	o the Hospital vithin 24 hours o the Funeral ompletely filled	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best iner: On the basis of and manner st	of my knowledge, death	h occurred at the ti- vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner at	as stated. ue to the cause(s)
	Mithin To the	Me	29b. Signature and title of certifier	and manner of		29c. Licens	se number	29	d. Date signed (Moi	nth, Day, Year)
			1 Sout	·~	MD	D	5839		9-18	-06
	le		30. Name in a dress of p in who	20, N	death (Item 23a) (Type,	Print) Toll	House	Ane,	Fred	eriel, Mp
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 8 200		rar's Signature	enti		,		21701

		4	For State Registrar	State of Maryl		partment of e <i>rtificate of</i>		nd Men		iene 🗕 🔾 🔾	0 23333
	Physicia		1. Decedent's Name (First, Middle, Las		0				Date of Deat Month	Day Yea	
	/Medic	a!	MORRIS  4a. Facility Name (If not institution, give	W.	ROL		or Location of		PTEMO	4c. County of De	
	Examine	er		ENTER		700		Ceatti		BALT	
Md	Funeral		5. Social Security Number 6. Se		yrs. last birthd	Months   Day		4 Hrs. 8. t	Date of Birth Month, Day,		Birthplace (State or Foreign Country)
8	Director		x11-29-1000	7	Yrs			FE	BRUARY	15, 1935	MARYLAND
50	land ow		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or	Location					10d. Inside City Limits
0	Mary a-f sh	ţċ	MD. CECIL	. co.	PERI	RYVILL	E				1 ☐ Yes 2 ☑ No
2	or 28;	Director	10e. Street and Number			10f. Zip Code			11	0g. Citizen of What	
0	e 23a	rai	100 GREENU	UAY AP1  12. Was Decedent Ever i	101		903	-0.40	V	U S	* /
90.	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	in U.S.	Was Decedent of If Yes, specify Cu		Puerto Rica	n, etc.)	Black, Wi	merican Indian, hite, etc.
-//	hours after deeth with the Maryland tural; or itame 23a or 28a-1 show al Examinar must be notified at	þ	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 N	o Specify:			Specify:	UHITE
) - 5-0	be filed within 72 hours after deeth with the Marylar Ital Hygiene. Id other than "natural", or itame 23a or 28a-1 show other than "natural", or itame 23a or 28a-1 show event, the MacJigal Examiner must be rotified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(G	cedent's Usual Occ	e during most o	of working		16b. Kind of Busines	ss/Industry
2.5	within 9ne. then	gmc	Elementary/Secondary (0-12)	College (1-4or 5+)	i	e. DO NOT use retii	•	- TO	7//	RG	E
2 S	Hygid other	Be C	17. Father's Name (First, Middle, Last)		DEF	_///\\CE				Maiden Surname)	
/fS /land	should be filed within of Mental Hygiene.  markad other than imatic event, the Mental Men	To B	MORRIS 4	J. ROWE	5		MA	RIE	/	MATTHA	21
Many	2 9 5		19a. Informant's Name/Relationship (7		19b. M					City or Town, State	.Zip Code) OTT CITY,
C. 2	1 and 2 Health tem 27		BRYAN ROWE / Se	120	b. Place of Di	50 BOA sposition (Name of	NIE L	BRAA Date	ICH I	PD MD 20c. Location - City	21043
nor	00		1 ☑ Burial 2 ☑ Cremation 3 ☐ 4 ☑ Donation 5 ☑ Other (Specify	Removal from State	cemetery, o	crematory or other p	lace)				
We,	permit. Pag Department Important: I any injury o	-	21. Signature of Funeral Service Licen		EUHK	22. Name and Add	ress of Facility	4001	06	BALTO	Y BALTO MD
3 <u>m</u>	permit. Departi Import any inj once.		I gerone Zu	murove	h.					EVICE P	
X			23a. Pm1. Enter the disease or comp shock, or heart failure.	ilications that caused the cone cause on each line.	death. Do not	enter the mode of d	ying, such as ca	ardiac or res	spiratory arre	est,	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a Transit	tion C	ell con	cer of	UY	eter		Onset and Death
9	/Medical Examiner		Tosulary in double	Due to (or as a con	nsequence of):		0				0
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	sequence of):						
ws.	ocuted nd transit	Examiner	that initiated events	c							
. 09			resulting in death) Last	Due to (or as a con	sequence of):						
09289	ficate I physi	edical	•	d							-
Box (	eath certif ettending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		• CT				23d. Date of d	delivery
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		3 □Ectopic pregnan 5 □ Other (specify)				Month	Day Year
P.O.	d by the deletached	Phy	9 Unknown  Part II. Other significant conditions co		rocultion in th	dash i	nuas in Cont.		220 Did tob	un den une ennetéhute	to the cause of death?
ds,		ک	Farm. Other significant conditions of	minouting to death but not	resulting in th	e underlying cause (	jiven in rait i.				Probably 4 Unknown
COL	w require	ompleted							24a. Was a	24b Were	autopsy findings available
Division of Vital Records,	: The lay cate has	d Lo				-		_	autops perform	y prior t ned2 death	o completion of cause of
ita	sician: Th certificate irector, pag	BeC	25. Was case referred to medical examiner?				26. Place of		neck only on		55 2 140
<u> </u>	Physic this ce at dire	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient		IIII 3 DOA				nce 6 Other (S	pacity) Hospice
on c	ding P. After funera	lon	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	er) 28b. Tim Inju	y W	uryat ork? ∐Yes 2∐N		Describe ho	w injury occurred	,
/isic	i or Attending after death. Director: After d in by the fune	flca	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm,			28f.			Rural Route Number.
ă	s afte s afte ed in t	Certification:	4 Homicide determined	building, etc. (Sp	pecify)				City or Town	, State)	
		edical	(Check only 2 Medical Exam	ysician: To the best of my nner: On the basis of exam	knowledge, de	eath occurred at the	time, date and	place, and	due to the ca	use(s) and manner ate and place, and d	as stated.
	To the P within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner stated.			nse number		··	9d. Date signed (Mo	
	1 3 1 8		IN Anthon	Roley us	2	02	5205	-	I .		m 12, 2006
	1,5		30. Name and address of person who	completed cause of death	(Item 23a) (Ty	pe. Print) Korles S	0 1	0.		1.	,
	W	1	W. A. Riley	64MC 67		horles !	t. Ba	lts.	Md	2120	
	Stat Registra	G	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	barte					

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

			For State Registrar		State	of Mary	yland / Dep <i>Ce</i>	oartme e <i>rtifica</i>					ieneZ	JUb	295	133	
	*		Decedent's Name (First, M	iddle, Las	(t)							2. Date of Deat	h		3. Time of	Death	
	Physici		Hubort E Bosome						Month Septer					per 8, 2006 7:03			
	/Medic Examin		Hubert E. Rogers 4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death					er 8, 2006 7:03 A <sup>M</sup> 4c. County of Death			
	_ Xaiiiii		Greater Baltimore Medical Center					Tow	son				Baltimore				
	Funeral		5. Social Security Number	6. Se		7. Age (I	n yrs. last birthda				8. Date of Birth	Date of Birth (Month, Day, Year)  9. Birthplace (State Country)			r Foreign		
	Director		226-34-6338		<b>∑</b> M 2□F		75 Yrs.	WORKER	Days	Hours	IVIII.	May 6,	1931		w Jerse		
2		'n	Usuat Residence of Deceden 10a. State 10b. Cou			10	Oc. City, Town or	continu							10d. Inside Cit	a Limite	
200	e d				276.0	"									1 🗆 Yes		
2	perim. Fagos I ariot should be incurrent if a hours are dean win his manyario perim. Fagos I ariot should be incurred the incurred from 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be rediffied at once.	ecto		1timo	).e		Baltim						0	- ( ) )		X	
this.		Funeral Director	10e. Street and Number 8820 Walthe	r Blv	√d #251	2		101. 2	ip Code	212	234		0g. Citizen	USA	unity ?		
100		era	11. Marital Status		12. Was Dec		or in U.S. 13	. Was Dec	edent of H	ispanic Ori	igin? (Spe	ecify Yes or No-			rican Indian,		
و ف			1 ☐ Never Married 2 🔯	Armed Forces?  1 ☐ Never Married 2 ☑ Married  I ☐ Yes, Give					If Yes, specify Cuban, Mexican, Puèrto F					Black, White			
3-0035		d b	3 Widowed 4 Divorced Year or Dates:					1 ☐ Yes 2X No Specify:						Specify: white			
ה ה	na ta	Completed	15. Dece (Specify only hi	dent's Ed	lucation de completed	)	(Gi	edent's Us	rork done	during mos	at of worki	ing unk	16b. Kind of	Business/I	ndustry	unk	
V 4	9 5	du	Elementary/Secondary (0-1	2)		(1-4or 5+)	life	. DO NOT	use retired	1)							
7	ygier t.		12 17. Father's Name (First, Mid		0					4D Marks		(First Mindels I	As info as Course				
yland	d of	To Be	Alexander Ro		•							e <i>(First, Middle, I</i> ces Smit		iame)			
	1 Men narke								cc /Street			al Route Number		um State 7	in Codol		
	7 is r																
ָבָּ בַּ	Heali em 2 ther		Anne Rogers/s 20a. Method of Disposition	spous	e	Ī	20b. Place of Dis	position (N	ame of		I #25	12 Balti					
בוביים בוביים	tment of rant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)														
			4 © Donation 5 Other (Specify)  21. Signature reuneral Service Licensee State Anatomy Board 655 W. Baltimore Street  State Anatomy Board 655 W. Baltimore Street														
ם מ	Depa Impo		21. Signature Funeral Sen	SI	Majles )	lirec	tor S	tate	Anat	omy B	oard	655 W.	Balti	more :	Street		
	cate be executed by Sician and Shape in the price of the		Baltimore, MD 21201  23a. Parti\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate														
			shock or heart failure 1 ist only one cause on each line														
			disease or condition resulting in death)	-	a	140 CC	armai	1840	urci	non					6 Nai	B	
			temediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									6 111	26				
		P.	Sequentially list conditions, if any, leading to immediate	onsequence of):	ney a searce					3 9006			106				
T C		ᇤ	Cause (Disease or injury														
J,		Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):														
orou,		dlcai															
		ed											-				
X S	andin	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy											23d. Date of delivery			
ם פֿ	e ette	Cla	in the past 12 months?  1 Vas 2 No.  4 Pregnant at time of death  5 Other (specify)										Month Day Year			ear	
)	by th	hys	9 Unknown 9 Unknown														
J. of	s been signed 2 should be dei	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								acco use c	co use contribute to the cause of death?  2 🗹 No 3 🗆 Probably 4 🗀 Unknown					
			sleep aprea 1 Yes 219								s 2 No						
ecords,		Completed	chronic senal farilure 24a. Was an								n 24	24b. Were autopsy findings available prior to completion of cause of					
ž į	ite ha	E	autopsy performed?  1 □ Yes 2 Ø No								death?	leath?					
	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	0	25. Was case referred to me	dical						26. Place	e of Death	(Check only on					
> ×		To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1	Inpatient	2 ER/Outpat	ent 3 🗆 [	Oth Oth	er: 4□Nı	ursing Ho	me 5 Reside	nce 6 🗆	Other (Spec	ufy)		
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UNISION		atlo															
<u> </u>		Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									ation (Street and Number or Rural Route Number, r or Town, State)					
5 §		Cer															
E C	Funer Funer tely fill	edical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
4	ithin 2 the mple	Med	29b. Signature and title of ce	tifier	ano ma	nner stated		2	9c. Licens	e number			9d. Date sin	ned (Month	, Day, Year)		
F	- ₹ E 8				otagi	, M.	D.			197	L		9-1				
-	T				- 1					7							
8			30. Name and address of per Rekha Mok 31. Date filed (Month, Day, Y	agi	GBM	? C 6	70/ N	char	les s	tree	t 1	Baltin	vor ,	MD2	1204		
√ <u>45</u>	Sta	ate	31. Date filed (Month, Day, Y	ear)	32.	Regionar's	Signature		de a						,		
77	Registr		CEI	1 A	2006	Repli	w St.	157234	er								

			1- For Amend item #7,1	State of MoerFH,G859,9	aryland / โ /18/06 TT	Depar <i>Cert</i>	tment of Heificate of L	ealth and N Death	lental Hy	giene 20	06	29536		
	Physici /Medi		1. Decedent's Name (First, Middle, Last) LOUIS & Schaefer							Date of Death North 12 Day Offer 5:35 P				
7	Examir		4a. Facility Name (If not institution, give Charleston Care		4b. City, Town, or Catonsvi]		*	4c. County of Death Baltimore						
	Funeral Director		217-05-0575	x XM 2□F 7. Ag	M 2□F 7. Age (In yrs. last birthday) 92 Yrs.			If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 03/20/	y, Year) 1914 N	Count	Birthplaca (State or Foreign Country) ryland		
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene Important: if Item 27 is marked other then "naturel", or Iteme 23s or 28s-f show any injury or other treumatic event, the Mudical Examiner must be notified at ance.		Usual Residence of Decedent  10a. State 10b. County		vn or Loca	Location 10d, Inside City Limits								
		tor	Maryland Baltimor	ville	e			1 ☐ Yes 2X No						
		Funeral Director	10e. Street and Number 719 Maiden Choice	333		10f. Zip Code 21228			10g. Citizen of What Country? United States					
21215-0036		<u>م</u>	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces?	Armed Forces?  1 XYes 2 No If Yes, Give			Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🎛 No Specify:			14. Race · American Indian, Black, White, etc. Specify: White			
5-0		Completed	15. Decedent's Ed (Specify only highest gra		16a	. Decede	int's Usual Occupa ind of work done d O NOT use retired)	tion uring most of work	ing	16b. Kind of Business/Industry				
121		Junc	Elementary/Secondary (0-12)	College (1-4or	5+) E		rician			Constru	struction			
nd 2		Be C	17. Father's Name (First, Middle, Last) Louis Schaefer					18. Mother's Nam	e (First, Middle,	Maiden Surnam	<sup>e)</sup> Unk			
yla	J Ment narke natic	5		Type (Print)	104	h Mailian	Address (Ctrasts	ad Number or Flu	n I Florida Alcumba	or City or Town	Ctata 7i-	Code) 24.220		
Maryland	tth and 2 sl		19a. Informant's Name/Relationship (Tatherine A. Schae				Address (Street a							
Baltimore,	permit. Pages 1 ar Depertment of Hea Important: if Item any injury or other ance.	1 3	20a. Method of Disposition  1 Burial 2 Cremation 3   4 Denation 5 Other (Specify		cemete	ery, crema	tion (Name of atory or other place f Faith	a) i	Date 5/2006	20c. Location · Rossvil				
Balti			2 Signature of Funeral Service (icen	see ,		41(	Name and Addres	s of Facility Huk	bard Fü , Balti	neral Ho more, Ma	ome, i	Inc. nd 21229		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physicien and positive completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
			Immediate Cause (Final disease or condition resulting in death)  Onset and Death											
			Due to (or as a consequence of):											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									<del></del>		
		xam												
8760,		d												
9		Φ.	IF FEMALE:	23c. If yes, outcome		- 30		-		1				
P.O. Box		by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Ectopic pregnancy Other (specify)		-	23d. Date of delivery Month Day Year							
		ed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							-1	co use contribute to the cause of death?			
Rec		Completed							24a. Was autor perfo	osy p ormed? d	Were autoportor to combeath?	sy findings available pletion of cause of		
/ita		Be	25. Was case referred to medical examiner?	cal 26. Place of Death (Check only one)										
of		7: To								Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
ion		atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28a. Date of Injury (Month, Day Year) 28b. Time of Injury			? /es 2 \( \sum No						
Division of Vital		Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	e of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						Route Number,			
		Medical	29a. Certifier (Check only one)  Certifying Ph	ysicien: To the best niner: On the basis of and manner st	of examination ar	je, death o nd/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)		
	To t To ti	Σ	29b. Signature and title of certifie	MD			29c. License	number (		29d. Date signed	(Month, E	200 <sup>(</sup>		
	VI		30 Name and address of person who	completed cause of	death (Item 23a)	(Type, P	rint)	vo C	atonsu.	16 N	nagli	W		
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1	8 2006 P	r's Signature	B.	Berli							

				T _ State	Department of Health and Menta Certificate of Death	al Hygiene 2006 29537
		Physici	an	1. Decedent's Name (First, Middle, Last)	2. Da	te of Death  onth  Day  Year  UC  3. Time of Death  Year  L  2.5 M
		/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	rthday) If Under   Year   If Under 24 Hrs. 8. Da (M. Months Days Hours Min.	te of Birth 9. Birthplace (State or Foreign Country)
	2	9		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	m or Location	10d. Inside City Limits
		death with the Maryland ms 23a or 28a-f ehow	Director	MD, BALTIMORE MI.	DD LE RIVER	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
		death wit ims 23a c	Funeral D	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	2/201 13. Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,	es or No- etc.)  14. Race - American Indian, Black, White, etc.
	980	ours after rai', or Ita Exemine	by	1 Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: WHITE
	altimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Marylan to f Health and Mental Hygiene. If Item 27 is marked other than "netural", or items 23s or 28s-f ehow or other treumatic event, the Modical Examiner with the notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
	ind 21	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ire M.	Be	17. Father's Name (First, Middle, Last)	MAIDTAIDANCE 18. Mother's Name (First,	Middle, Maider Surname)
9	Aaryla	2 should and Men Is marke	To	(1)	b. Mailing Address (Street and Number or Rura) Rout	e Number, City or Town, State, Zip Code)
0	ore, 1	Pages 1 and nent of Health int: If Item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 O'Cremation 3 Removal from State	of Disposition (Name of Date ary, crematory or other place	20c. Location - City or Town, State
131	altim	permit. Pages Department of Important: If it eny injury or once.		4 Donation 5 Other (Specify)  21. Signature of general Service Ligensee	22. Name and Address of Facility	E BALTO JUD.
00		205 a		23a. I art 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or resp	ratory arrest, Approximate Interval Between
		Physician /Medical	1.	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	Cancel	Onset and Death
30		Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of).	
10	,00	certificate be executed nding physicien and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):	
)	09289	rtificate bong physic	Medical	d.		
use	O. Box	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery  Month Day Year
hou	Records, P.O.	sign d be	٥	Part II. Other significant conditions contributing to death but not resulting in	in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?  1 1/2 Yes 2 No 3 Probably 4 Unknown
uck	Reco	The law requate has been page 2 should	Completed			4a. Was an autopsy autopsy findings available prior to completion of cause of death?  ☐ Yes 2 ☐ No
3.4	Vital		Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Che	ck only one)
4	of	Attending Physician: r death. ector: After this certifica by the funeral director, p	tion: To	27. Manner of Death 28a. Date of Injury 28b.	dipatient 3 DOA 4 Norsing Rome 3	Escribe how injury occurred
3	Division	or Atter after dea Director in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ta building, etc. (Specify)	arm, street, factory, office 28f. Lc	ocation (Street and Number or Rural Route Number, ity or Town, State)
Tose		Hospital or 24 hours afte Funaral Dir etely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	e, death occurred at the time, date and place, and dund/or investigation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
11)	_	To the Hos Wit in 24 ho To the Fund corr pletely f	₽ S	29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
	J,	- V		30. Name and address of person who completed caule of death (Item 23a),	924170	Sept. 1, 2006
É	7			E.TSOMD Richer Howice	838 NEutaw St B.	Sept. 1, 2006 attimore MD 21201
		St Regist	ate rar	31. Date filed (Month, Day, Year)  SEP 1 8 2006  32. Figisfrar's Signature	Figure	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20b, c per fh 9859 9-21-06 vt
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Maryland / Dep Ce	aftment of Health and i rtificate of Death	Mental Hygie <sub>Reg.</sub>	ZUUr	29538
	Physici	an.	1. Decedent's Name (First, Middle,			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Eileen Stu			09	15 2000	
	Examin	er	4a. Facility Name (If not institution, of University of Marylar		4b. City, Town, or Location of Deat Boltimore	n	4c. County of Dea	
	Funeral			. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Bir	thplace (State or Foreign
Ш	Director		216-56-6973	1□ M 200 F 56 Yrs.	Months Days Hours Min.	Murch	1950 N	laryland
	land ow		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		<u> </u>	10d. Inside City Limits
	Mary a-f sh	tor	Md. NI	A Balt	imore			1 XYes 2 □ No
	death with the Maryland ims 23a or 28a-f show r must be notified at	Jred	10e. Street and Number	-11 11	10f. Zip Code	10g.	Citizen of What Co	ountry?
	s 23e	rail	4102 We	St bay Ct.	12/225		USI	4
	frer de	Funeral Director	11. Marital Status 1 Nover Married 2 Married	12. Was Decedent Ever in U.S. 13. Armed Forces?  1 □ Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
93	raf', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 No Specify:		Specify: B	lack
21215-0036	within 72 hours after ene. then "natural", or Ite he Medical Examina	Completed	15. Decedent's (Specify only highest	grade completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking 16t	. Kind of Business	/Industry
712	ed withir giene. er then	d mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Care Privide	- 3	tato 0	FM1.
	be filed tal Hygi d other event.	BeC	17. Father's Name (First, Middle, La	st)	18. Mother's Nar	me (First, Middle, Main	den Sumame)	1.163
<del>y</del> a	Ment Ment	ှ	William .	Johnson	Eva	Stuk	es	
Maryland	ind 2 should alth and N		19a. Informant's Name/Relationship	(Type, Print) daughter) 196. Maili	ng Address (Street and Number or Ru $\Delta$	iral Route Number, Ci	ity or Town, State, .	Zip Code)
	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispo	ryution (Name of) malor) or other place)	Date 200	: Location - City or	Town, State
imo	Page nent c		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Linemoval from State	Cometery 4/21	12006 ]	Sunda.	IK Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show sny injury or other traumatic event. The Medical Examiter must be notified at once.		21. Signature of Funeral Service Lic	censee O O	2. Name and Address of Facility	ineral 1	tome. P.	A.
	202 # 4		23a. Parn Enter the disease, or co	emplications that caused the death. Do not en	ZZEVV North A	or respiratory arrest.	ito. Ma	Approximate
	Pnysician	0 1	shook, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each line.				Interval Between Onset and Death
ı	/Medical Examiner		resulting in death)	a Due to (or as a consequence of):	ma			
	Examine		Sequentially list conditions,	b. Hypertension				
0	uted d ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		opathy.			
ÎD	e exec ien an ırial-tr		resulting in death) Last	Due to (or as a consequence of):				
68760 <sup>D</sup>	tificate be executed g physicien and as the burial-transit	edical		d. Abdominal of	Did		_	
_	certifi nding l		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of de	livery
Box	The law requires that the death cert sie has been signed by the attending page 2 should be detached for use a	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		□Ectopic pregnancy □ Other (specify)		Month	Day Year
P. 0.	d by the	Phy	9 🗷 Unknown	s contributing to death but not resulting in the u	andestrine access to Death	02a Didashar		the cause of death?
ds,	uires ti signe Id be c	d by	ratii, other significant conditions	s contributing to death but not resulting in the b	inderlying cause given in Part I.	1 ☐ Yes		obably 4 🗷 Unknown
S	s beer shou	Completed				24a. Was an	24b. Were au	utopsy findings available
<u>~</u>	The la	E O				autopsy performed 1 ☐ Yes 2 😿	death?	completion of cause of
Vita	Physician: r this certificant at director, I	Be	25. Was case referred to medical examiner?	Hospital:	10.	th (Check only one)		
ō	Phys	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury 28b. Time o		ome 5 Residence		cify)
<u>io</u>	Attending or death.  ector: After by the fune	atlor	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year) Injury	f 28c. Injury at Work?  M 1 Yes 2 No		,,	
Division of Vital Records,	after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		reet, factory, office	28f. Location (Street City or Town, S.	t and Number or Ri tate)	ural Route Number,
	ours a peral Deral Dilled		29a. Certifier 1 Certifying	Physician: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the cause	o(c) and manner as	ctatod
	To the Hospital or Attending Physician: The law requires tha within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	Medical	(Check only 2 Medical Ex	aminer: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mont	* *
•			to e	DO	P19758		09/15/	06
	\			to completed cause of death (Item 23a) (Type, 22n Street. Baltimore Mi	Print) D 21201 - Departr	ment of Ane	o the viology	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature				
	Registr	ar	SEP 182	UUD BRUKE ST SOP				

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State of Maryland / Department of Health and Mental Hygiene 2006	295
State of Maryland / Department of Fleatiff and Merital Hygiene 2 0 0	600
Contificate of Dooth	

			For State Registrar			f Marylan	d / Depa		of H	ealth a			giene 2 Reg. No.	006	295	39
	Physici	an	1. Decedent's Nam	e (First, Middle,		rine M.	Sever	e				2. Date of De Month	Day	Yeer	3. Time of Deat	th M
	/Medic Examin	- 4	4a. Facility Name (	() 1	give street and nur		ker		Sali	Location	1	Septemb	4c. Cou	nty of Death	U	
	Funeral Director		5. Social Security N 213 30	Number J 6	6.Sex 1 □ M 2 🗗 F	7. Age (In yrs. 72	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Sept.	<sup>th</sup> Year) 4, 1934	9. Birthi Coul 4 Mar	place (State or Fore ntry) y land	eign
	yland how		Usuat Residence of	10b. County			ty, Town or Lo								10d. Inside City Lin	
09	the Ma	Director	Maryland  10e. Street and Nu	Worce	ster	(	Ocean (	101. Zip	Code				10g. Citizen	of What Cou	1 ☐ Yes 2Å	No
83	23a or	ai Dir		· 14th St	treet				218				U.S			
43-30-8760 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other treumatic event, it a Medical Examinar must be notified alonge.	by Funerai	11. Maritat Status 1 Never Man 3 Widowed	ried 2□ Marrie 4 🛣 Divorced	Armed Fo	2 🔯 No /8	1	Was Deced If Yes, spec				ecify Yes or No Rican, etc.)		Race - Ameri Black, White, cify: Whi	etc.	
2/3 3	within 72 ho ene. then "natur	Be Completed	(Spe Elementary/Seco 6th		Education grade completed) College (1	I-4or 5+)	(Give	dent's Usua kind of wor DO NOT us emaker	k done d e retired	ation during mos	st of worki	ng		r Business/Ir n Home		
ਰ	ould be filed Mental Hygi arked other atto event, I	To Be C	17. Father's Name	Jam	es J. Duf	fy					Gert	(First, Middle rude Mc	Gee			
Serere. Marylan	nd 2 shuith and 27 le m		19a. Informant's N Deborah		p <i>(Type, Print)</i> inst / Da	ughter	1	ng Address - 14th				<i>N Rout</i> e Numb Cean Ci				
, e	ges 1 ar it of Hea if item or othe			☐ Cremation 3	3 □Removal from		Place of Disponentery, cre					ate		on - City or T		
Baltimore,	mit. Pa partmer portent: / Injury	1	4 ☐ Donation 21. Signatur	5 Other (Spenier I envice Li			ndon P								Maryland e, P.A.	
B 26	FO F G		230 Part Fotor	the disease or s	omplications that of	eaused the deat						<u> </u>		, Mary	land 2122	25
	Physician		Immediate Cause disease or conditi	(Final on	omplications that only one cause on e	. /	ephc			9, 000					Interval Between Doset and Death	
	/Medical Examiner		resulting in death)		1	(or as a conseq	uence of):								month	
.12	ted nsit	Examiner	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated event	erlying r injury	U	(or as a conseq	(uence of):									
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68	ificate g phys as the	ledical			d											
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be eviluin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien completely filled in by the funeral director, page 2 should be detached for use as the burial.	by Physician/Med	IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months? ☑No	1 ☐ Live b	tcome of pregna birth 2 Peta nant at time of d own	il death 3	□Ectopic pr □ Other (sp						Date of deliv Month	ery Day Year	
rds, P.	quires that t an signed by uld be deta	ed by Ph	Part II. Other sign	ificant condition	s contributing to d	eath but not res	sulting in the u	underlying c	ause give	en in Part I	ı. 		tobacco use c Yes 2 ☐ No	-	the cause of death?	- 1
H Reco	The law re cete has be page 2 sho	Completed										24a. Was auto perfo 1 - Yes	psy pmed?	b. Were auto prior to co death? 1  Yes	opsy findings available on pletion of cause 2 No	able of
Vita	rsiclan: s certific director,	To Be	25. Was case reference examiner? 1 \( \text{Yes} \) 2 \( \text{\text{W}} \)		Hospital:	Inpatient 2	] ER/Dutpatie	nt 3 🗆 DQ	A Othe	25		n (Check only		Other (Speci	(v)	
ion of	anding Phy ath. or: After thi	Certification: T	27. Manner of Dea 1 Naturat 2 Accident	ath 5 Dending investiga	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work	at at	-21	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Divis	al or Att s after de al Direct	Certific	3 Suicide 4 Homicide	6   Could no determin	ned 289. Place	of tniury · At hing, etc. (Special		reet, factory	, office			28f. Location ( City or To	Street and Nu wn, State)	ımber or Rur	al Route Number,	
	e Hospit 24 hour 16 Funer	Medical (	29a. Certifier (Check only one)	1⊠ Certifying 2  Medical E	Physician: To the xaminer: On the b and man	best of my kno asis of examina ner stated.	owledge, dear ation and/or in	nvestigation,	in my o	pinion, dea	ath occurr	ed at the time,	date and place	manner as s ce, and due t	itated. o the cause(s)	
	To the To the Comp	Ž	29b. Signature an	d title of certifier				290	Mich	ael F	elder	D.O. 64534	29d. Date sig	gned (Month,	Day, Year)	
	4				no completed caus			, Print)	Lice	nsen	1100	1	<u> </u>	-, -		
	Sta		Michael 31. Date filed (Mo	onth, Day, Year)		Registrar's Signa	ature	1 3/.	4	5.461.	20419	1 ///	<u></u>			
	Regist	rar		SEP 1	8 2006	Santa s	H.	Book	2							

DHMH 17 Rev 1/2001

Dhyaia	a p	1 - For Amend #26 Pt Registrar  1. Decedent's Name (First, Middle, Last)						2	Date of De	ath	200	3. Time of Death
Physic /Medi			tewart						ept.	10	2006 <sup>Yea</sup>	12:55pm M
Exami	ıer	4a. Facility Name (If not institution, give street 3 York Drive	and number)		Port		Location of	Death			County of De $f cil$	ath
Funeral	₩.	Social Security Number 6. Sex		. last birthday)	If Under	1 Year	If Under 2	4 Hrs. 8	Date of Bir			irthplace (State or Foreign
Director		233-28-7026 <sup>1□ M</sup>	<sup>2</sup> X	87 Yrs.	Months	Days	Hours	J.	Date of Bir (Month, Da une 12	, 19	19 We	country) est Virginia
land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
Mary	tor	MD Cecil	Po	rt Depo	sit							1 ☐ Yes Ž No
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28a-f ehow int, the Medicel Exantral must be rediffed all	Oirec	10e. Street and Number			10f. Zip			-		-	en of What	Country?
permit. Pages I and z should be lied within 72 hours affer death with the Marylar Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Macical Examinar must be notified at once.	Funeral Director	3 York Drive	Vas Decedent Ever in U	18 12		904	coopie Orie	in? /Coppi		U.S.		nerican Indian,
r Item	Fun	1 Never Married 2 Married 1	.med Forces? ☐ Yes 2 2 No			xx.		Puerto Ri	fy Yes or No can, etc.)	1	Black, Wi	nite, etc.
Ever 1	by		Yes, Give ear or Dates:		1 ☐ Yes 2	2 <b>23.</b> No	Specify:				Specify: Ca	ucasian
natu	Completed	15. Decedent's Education (Specify only highest grade con	n n <i>pl</i> eted)	16a. Dece	denI's Usua kind of wor DO NOT us	al Occupa	ition Juring most	of working	7	16b. Kir	nd of Busines	ss/Industry
Hygiene.  Kher than  ont, the Ma	duc		college (1-4or 5+) years		с Турі		,			Zip	per Fa	ictory
othe othe vent,	BeC	17. Father's Name (First, Middle, Last)							First, Middle,	Maiden		
ind Mental I	To E	James H. Nottingham	1						naberr	•		
h and 7 is me raume		19a. Informant's Name/Relationship (Type, F			-				Route Numbe		Town, State	, Zip Code)
Health tem 27 other tr		Arnold W. Stewart,  20a. Method of Disposition		Place of Dispo	sition (Nan	ne of		Depo	sit, M			or Town, Slate
rages nent of I int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)		tro Cre	-		1	9-12-	06	Balt	imore,	MD
permit. rag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	1110									1 Home, Inc
8 8 E 8 8		14-1098							ltimor		D 212	206
		23a. Part J. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the dea use on each line.	ith. Do not ent	er the mod	e of dying	g, such as o	cardiac or i	respiratory a	rrest,		Approximate Interval Between Onset and Death
nysician Medical		Immediate Cause (Final disease or condition resulting in death)	Corma	14 /	loft	vy	1	7,50	ase			
xaminer			Due to (or as a conse	gruence or):	Hà	nor	+ 1	5011	line			
11/-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conse	quence of):	- 1 1 -			W u	41 -		<del></del>	
transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D /									
he burial-transit	cal Ex	rosating in dodair, Last	Due to (or as a conse	quence or):								
ate hes been signed by the ettending phys page 2 should be detached for use as the		d										
ettending phy for use as th	Physician/Med	23b. was decedent pregnant	yes, outcome of pregr □Live birth 2 □Fet		∃Ectopic pr	eanancy				2	3d. Date of c	•
ed by the ettendin detached for use	sicia	1 Yes 2 No	Pregnant al time of		Other (sp						Month	Day Year
d by t		9 ☐ Unknown  Part II. Other significant conditions contribu	iting to death but not re	sulting in the u	ndertvina c	ausa niva	n in Part I		23e. Did t	obacco u	se contribute	to the cause of death?
5,8	d by	,		,		uuoo g			10		/	Probably 4 Unknown
s been si	Completed								24a. Was		24b. Were	autopsy findings available o completion of cause of
ate he	E O								autor perfo	osy orpoed? 2 2 No	prior t death 1 \( \supers	? N.
ertifice ctor, p	Bec	25. Was case referred to medical examiner?		,			26. Place	of Death	Check only	-	E.	
this certificated rail director,	2	1 □ Yes No	1   Inpatient	Outpatier	_		4 🗀 1901		e 5 <b>X</b> Xesi			pecify)
After funer	tion:	Natural 5 Pending	Ba. Date of Injury (Month, Day Year)	28b. Time o Injury	M 2	8c. Injury Work	raj (? Yes 2.⊟h		d. Describe	now injury	occurred	
or death.	Certification:	3 Suicide 6 Could not be	Be. Place of Injury At I	home, farm, st								Rural Route Number,
safte al Dire ed in t	Cert	4 Homicide	building, etc. (Spec	uty)					City or To	wn, State,		
unar unar sly fill	Medical	(Check only 2 Medical Examiner:	on the basis of my kn	rowledge Jest nation and/or in	h conumed	at this tim	is, date and	t placa, an	d due to the	cause(s)	and manner place, and d	ue to the cause(s)
	D	one) 29b. Signature and title of certifier	and manner stated.			c. License						nth, Day, Year)
thin 24	Σ	N/ A	=> MI			100	567	68		9	112/	26
within 24 hours after death. To the Funaral Director: After this certificate has ormpletely filled in by the funeral director, page 2	Σ	111. 114				_	1 16	-		//	1-1	
within 24	M	30. Name and ad res of erson complete	eted cause of death (Ite	om 2) (Type,	Print) j		0	10 1	3			211
To the Complete	Σ	30. Name and ad rest of terson completed	28/ E-1	Mary	Print)	1.1	25/2	g S.	un v	Vas	219	//
H	ete.	30. Name and ad res of erson completed (Month, Day, Year)	28/ 32/Registrar's Sign	Mary	Print)	11	25/2	9 5.	un,	Vas	219	//

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 29541 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Beulah I. Stephonic Sept 15, 8:45am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Riverside Harford Belcamp If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Sept 15, 1915 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax 7. Age (In vrs. last birthday) **Funeral** Months Days 1□M 2 217-80-9730 Director Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits worle 1 Yes 2 No Director 28a-f MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural', or Iteme 23a 4 Poplar Grove Avenue 21001 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item eny injury or other traumatic event, the Medical Exemples. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Caucasian 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3rd grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank McCauley Josephine Gaines ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bernice M Scholtholt, daughter 4 Poplar Grove Avenue, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 20, 2006Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6415 Belair Road, Baltimore, Maryland 21206 23a. Parti. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myoradial **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of Examiner The law requires that the death certificate be executed. attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical TE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the th 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 Yes 2 10 hironhronia, 3 Probably 4 Unknown Completed 24a. Was an autopsy perform d? 24b. Were autopsy findings available prior to completion of cause of death? a nomia 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; p 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Other: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatien1 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Datural 2 Daccident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Medicai 29a. Certifier [[] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) um 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mail

Regietrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, SEP

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. Registrar's Signature

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2006

hysici	an	1. Decedent's Name (	First, Middle,	Last)			СПИІ	LOWI	Т7		. Date of De Month EPTEMB		(4 20\06		me of Deatl
/Medic	al	HARRIS  4a. Facility Name (If no	ot institution	nive street and num	nher)		4b. City, To				EF I EMD		. County of De		30 A
Examin	er	5 NEWBRIG					RANDA						BALTIMO		
uneral rector		5. Social Security Num 216-20-04	nber 6		7. Age (In yrs. la <b>79</b>	ast birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours		Date of Bir (Month, Da 1/04/1	927	9. B	Sirthplace (S Country)	
*		Usual Residence of De 10a. State	ecedent 0b. County		10c. City	, Town or Lo	ocation							10d. Insi	ide City Lir
f eho	ō	MD	BAI T	IMORE		RANDAI	LSTOW	N						1	Yes 2
1 28a	rec	10e. Street and Number					10f. Zip C					10g. Cit	izen of What	Country?	
238 0	a D	5 NEWBRII	DGE COL	JRT			21	133				ŧ	J.S.A.		
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sician edical miner	ai Examiner	Immediate Cause (Fir	nal itions, ediate ring ury	a	aused the dath ach line. or as a consequence as a consequence or a conse	phoe of);  LLUL  Jence oi);	ter the mode	of dying	, such as		espiratory a		KESVILL	Appro Interva Opset	212 ximate al Betwee al d Dea
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month IAM **Physician** leanor Steer 06 /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Morningside House of Satyr Hill Parkville Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Feb 23, 1917 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Deys Months Hours 1 □ M 2 1 F 89 Maryland Director 212-07-8222 Usuel Residence of Decedent be filed within 72 hours efter death with the Marylend 10d. Inside City Limits 10h County 10c. City. Town or Location 10a. State permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryle Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any Injury or other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Directo MD Baltimore Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8800 Old Harford Road 21234 USA Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: δ white 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 executive assistant pharmacutical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael J. Curran Mary Dorn ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Michael Steer/nephew 817 Staffordshire Road Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Dixector đe. 21201 Baltimore, MD Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Man Examiner Physician/Medical Examiner attending physicien end for use es the bunal-transit Tha lew requires that tha death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ ed bluods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed peen To the Hospital or Attending Physician: Tha lew within 24 hours after death.

To the Funeral Director: After this cartificate has I completely filled in by tha funeral director, paga 2: 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the state of the country of the basis of examination and/or investigation in my opinion death occurred at the state of the country of the basis of examination and/or investigation in my opinion death occurred at the state of the country of the basis of examination and/or investigation in my opinion death occurred at the state of the country of the basis of examination and/or investigation in the basis of examination and/or investigation and on the basis of examination and/or investigation and on the basis of examination and/or investigation and on the basis of examination and/or investigation and or investigation and o Medical 29a. Certifier (Check only Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and magnetic stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1) 45475

State Registrar RAHMAMA M.D., 9512 HARFORD Rd #4: BALTIMORE MD 21234

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

2006

32. Registrer's Signature

JOHAMMAD

31. Date filed (Month, Day, Year) SEP 1 6

		•	For State Registrar	tate of Maryland /	Department of H Certificate of I		lental Hygi	ene g. No. 2006	29544
ı	Physicia		1. Decedent's Name (First, Middle, Last)	d Toth			2. Date of Death Month		3. Time of Death 4-15 AM
>	/Medic Examin	er	4a. Facility Name (If not institution, give stree TVY HALL GERIATA	et and number)		Location of Death		4c. County of Death	2.6
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOVEMBER	9. Birth (Co. 1), 1921 M/	nplace (State or Foreign intry) RYLAND
	ryland		Usual Residence of Decedent  10a. State 10b. County	2 ==	wn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the Ma or 28a-f s	Director	MD, BALTIN  10e. Street and Number		LT/MORE  10f. Zip Code		10	g. Citizen of What Co	
	ems 23a	Funerai [	11. Marital States	Was Decedent Ever in U.S. Armed ≨orces?	13. Was Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
0036	nours after urel', or it	by	3 Widowed 4 □ Divorced	I Des 2 No If Yes, Give Year or Dates: WW ∏	.1				HITE
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "naturel", or Items 23a or 28a-f show event, Ire Medical Evarifret must be rutilled at	Completed	15. Decedent's Educatie (Specify only highest grade co		a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired LITHO G/	during most of work f)	ing	6b. Kind of Business/	
S	be filed ital Hygi id other event, I	To Be Co	17. Father's Name (First, Middle, Last)	TOTH		18. Mother's Name		aiden Sumame)	NER
Maryland	S a a	Ĕ	19a. Informant's Name/Relationship (Type,		Pb. Mailing Address (Street	and Number or Run		City or Town, State, Z	
nore,	m 0		20a. Method of Disposition  1 Burial 2 Cremation 3 Rem.  4 Donation 5 Other (Specify)	20b. Place cemel	of Disposition (Name of tery, crematory or other place	:e)	Date 2	0c. Location - City or	Town, State
Baltimore,	permit. Page Department Important; if any injury or once.		21. Signature of Funeral Service Licensee	GLEN	22. Name and Addre	ss of Facility 408	OI RITCI	HE HWY	BALTO MD.
			23a. Part1. Enter the disease of complication shock, or heart failure. Lief only one of Immediate Cause (Final	ause on each line.	not enter the mode of dyir	ig, such as cardiac	or respiratory arre		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	Desto (or as a consequence		amonia Dyspho			
15.	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Jue to (or as a consequent	e of):	ad 2 buc	414		
8760,	ate be executed hysician and the burial-transit		that initiated events c resulting in death) Last	Due to (or as a consequence	e of):				
9	eath certificate attending phys I for use as the	/Medicai	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy				23d. Date of del	very
.O. Box	at the death by the atter stached for u	Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □ Ectopic pregnancy 5 □ Other (specify) □	<i>'</i>		Month	Day Year
<u>α</u>	uires that signed b	by	Part II. Other significant conditions contrib	outing to death but not resulting	in the underlying cause give	en in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pr	the cause of death?
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ompieted					24a. Was ar autopsy perform	prior to death?	topsy findings available completion of cause of
Vital	Physicien: T this certificate ral director, pa	BeC	25. Was case referred to medical examiner?	nital:	Ott		h (Check only one	)	
of	ding Phys h. After this of funeral dir	ion: To	27. Manner of Death  1 Natural 5 Pending	1   Inpatient 2   ERV	Time of 28c. Injury Wor	y at	ome 5 Resider	nce 6 □Other (Spe w injury occurred	cify)
Division	or Atten fter deat irector: n by the	Certification:	a Could not be	28e. Place of Injury - At home, building, etc. (Specify)			28f. Location (Str City or Town	eet and Number or Ro State)	iral Route Number,
_	To the Hospitel of within 24 hours at To the Funeral Completely filled in	Medical C	29a. Certifier 1 Certifying Physici (Check only one)	en: To the best of my knowled: On the basis of examination and manner stated.	lge, death occurred at the til and/or investigation, in my o	me, date and place, ppinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier		29c. Licens			d. Date signed (Mont	
•	KY		30. Name and address of person who comp			06190		4/11/06	
	St	ate	31. Date filed (Month, Day, Year) 8 20	M D 32. Registrar's Signature	1124 M	ace Ave	nue, s	autimole .	, MD 21221
	Regist	rar	2FLT 0 50	No contract	-				

		1 - For State Registrar		State of I	Maryland / I	Departm <i>Certific</i>	ent of H cate of L	ealth and N Death	Mental Hy	giene Reg. No.	2006	29545
1000 pt 1000 p	ician dical	1. Decedent's Nam	ne (First, Middle, L C. Teiche						2. Date of De Month Septemb	Day	Year 2006	3. Time of Death  1:10 PM M
	niner	4a. Fecility Name	(If not institution, g	ive street and numb	er)	4b.	City, Town, or	Location of Death	-		ounty of Death	1
Programme of the second				ral Hospi			Olney	If Under 24 Hrs.	1.0. (0)		ntgome	
Funer Direct		5. Social Security I  229-26-3  Usual Residence of	3330	Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last bi	Mor	nths Days	Hours Min.	8. Date of Birt (Month, Da Oct 1,	1915	Cou	nplace (State or Foreign intry) inia
land land	ş	10a. State	10b. County		10c. City, Tow	m or Location	1					10d. Inside City Limits
Many	ţ	MD	Montgom	ery	Si1	ver Sp	ring					1 ☐ Yes 2√ No
Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or teme 23e or 28e-1 show eny injury or other traumatic event, the Medical Estatinar mantles inclined an outlined as	Funeral Director	10e. Street and Nu	umber orbrook I	Orive		10	f. Zip Code	20905			n of What Cou	untry?
death	era	11. Marital Status	orbrook i	12. Was Decede		13. Was [	ecedent of Hi	ispanic Origin? (Si n, Mexican, Puerto	pecify Yes or No	. 14	ISA Race - Amer	
urs after II, or Ite	by Fur		ried 2 Married	Armed Force 1 Yes 2 If Yes, Give Year or Date	X No	-	es 2 <b>X</b> No	Specity:	o Rican, etc.)	}	Black, White	
2 ho	ted	(500	15. Decedent's	Education	16a	. Decedent's	Usual Occupa	ation during most of work	kına	16b. Kind	of Business/li	ndustry
A I A I D-UUSO Id within 72 hours aff giene. or then "naturel", or If the Moulcal Exami	Completed	· Elementary/Sec	ondary (0-12)	College (1-4	or 5+)	life. DO N	OT use retired	) )	nii iy			
ed wi	Son	12		2		homer	naker	10.14 15 1.14	//** . 14:33		n home	
Maryland of 2 should be file th and Mental Hy 27 is marked oth traumatic event	Be	17. Father's Name	(First, Middle, Las					18. Mother's Nam	ne <i>(First, Middle,</i> Mary Ha:		urname)	
hould d Mer narke	၉		s Samuel		101	h Mailina Ad	drass (Strapt	and Number or Ru	<del></del>		Town State 7	in Code)
Ma d 2 st th and 7 ls n traun			vame/Helationship Leinberg/	-				ok Drive		-		20905
1 and 1 and Healt Healt		20a. Method of Dis		daugnter	20b. Place of	of Disposition	(Name of		Date	_	g, IID Ition - City or T	
altimore, rmit. Pages 1 a partment of Hea portant: If Item y injury or othe		1 🗆 Burial 2		Removal from Sta	cemete	ary, cremator	or other plac	θ)				
Dermit. Departr Imports eny inje	- SDC	21. Signature of 5	onald S	Wade, O	A Single			omy Board MD 2120		Balt	imore	Street
Physicia /Medic		23a. Part1. Enter shock, of he Immediate Cause disease or condit resulting in death	the disease, or co art failure. List on (Final ion	mplications that cau by one cause on each	sed the death. Do h line.	not enter the	mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
Examin	er	Sequentially list of	onditions,	b	as a consequence							
uted d ansit	Examiner	if any, leading to cause. Enter Und Cause (Disease of that initiated even	derlying or injury			,						
<b>56 / 50,</b> tificate be executed g physician and as the burial-transit	al Exa	resulting in death)		C. Due to (or	as a consequence	of):						
OC Illicate g phy as the	edical											
. BOX death cer e attendir of for use	Physician/M	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?		n 2 ☐ Fetal death it at time of death		pic pregnancy er (specify)			23	d. Date of dein Month	very Day Year
law requires that the das been signed by the 2 should be delached	۵	Part II. Other sign		contributing to deal	h but not resulting	in the underly	ving cause give	en in Part I.	23e. Did t	,	1	the cause of death?
VITAL RECOTGS, sician: The law requires t certificate has been signe	Completed								24a. Was autop perfo		prior to c death?	topsy findings available ompletion of cause of
ftal ian: ruffica	Se C	25. Was case refe	erred to medical					26. Place of Dea	ath Check only			
	ToB		No	Hospital: 1 Dinp	atient 2 ER/O	utpatient 3	DOA Oth	er: 4 🗆 Nursing H	lome 5 Resi	dence 6	Other (Spec	uty)
n of ng Phy ffer this neral d	.uc		ath 5 Pending	28a. Date of (Month,	Injury 28b. <i>Day Year)</i>	Time of Injury	28c. Injun Wor	y at k?	28d. Describe	now injury	occurred	
VISION Attending r death. ector: After	atic	2 Accident	investigat	ion		N		Yes 2□No				
- P + P - C	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	ad 286. Place of	Injury - At home, f , etc. (Specify)	arm, street, f	actory, office		28f. Location ( City or To		Number or Ru	ral Route Number,
DIVISIC DIVISION To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical			Physician: To the bi aminer: On the bas and manne	is of examination a r stated.	nd/or investig	ation, in my o	pinion, death occu	irred at the time,			
To th withir	Σ	29b. Signature an	nd title of certifier	h.			29c. Licens	e number		29d. Date	signed (Month	n, Day, Year)
		Dr.	Mul	1//111			D 00	059414	,	09/0	08/06	1
		30. Name and add	dress of person wh	pompleted cause	of death (Item 23a)  Orivee  intrar's Signature	Phil,	p Dr	Olue	y M	0	2083	32
Office and	State	31. Date filed (Mo	onth, Day, Year)	32. Rec	istrar's Signature							
Reg	istrar	d	SED 1 A	2006	leeve to	dos	refer					
DHMH 17 Rev	1/2001		OF! T									

ORIGINAL

		•	For State Registrar	State of Maryland		irtment of H tificate of L			ene g. No. 2006	29546
	Physici	an	1. Decedent's Name (First, Middle, Last)	ABELL VAS	9080	7		2. Date of Death Month	Day Year 13 2006	3. Time of Death  /: 36 /3 M
	/Medio Examin		4a. Facility Name of not institution, give s			4b. City, Town, or	Location of Death		4c. County of Death	7.0
	Funeral Director		5. Social Security Number  2/5-50-9364  Usual Residence of Decedent	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthy Coun	place (State or Foreign http)
	death with the Maryland sms 23a or 28a-f show ir rival be collified at	tor	10a. State 10b. County	0	Town or Lo				1	0d. Inside City Limits  1 ✓ Yes 2 □ No
	with the	i Direc	10e. Street and Number	Alla		10f. Zip Code	7	10	og. Citizen of What Coul	ntry?
36	after or it	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed N Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
215-0036	within 72 hours. ene. than "natursi", the Medical Exa	Completed b	15. Decedent's Edu (Specify only highest grade	cation	(Give	lent's Usual Occupa kind of work done o OO NOT use retired	furing most of wo	rking	16b. Kind of Business/In	dustry
and 21	id be filed ental Hygi kad othar ic svsnt. I	То Ве Соп	17. Father's Name (First, Middle, Last)		Teleco	inmunicat		ne (First, Middle, A		/Blue Shield
e, Maryl	1 and 2 shou fealth and M sm 27 is mar ther traumat	_	19a. Informant's Name/Relationship (Ty Ross N: Jones 20a. Method of Disposition	1BroTHER	5131	CHALL	and Number or Ru	Iral Route Number,	City or Town, State, Zip.  20c. Location - City or To	md 2/211
altimor	permit. Pages 1 Depertment of h Important: If Its any injury or ot once.		Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)  21. Signature of Funeral Service 40 ns	emoval from state Dal	aney		ss of Facility	20/06 -	Timorium - Nami to	Md DENAL NOME
Ä	Depermination of the contract		253. Part 1 Enter the disease, or comple						Bothouse	Approximate Interval Between
8760,	The law requires that the death certificate be executed to the steep signed by the ettending physicien and the property and the steep 2 should be detached for use as the burial-transit	ilcai Examiner	shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):	l in	farca	400	}	onset and Death
O. Box 6	at the death certifics by the ettending pt tached for use as a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decent of the control of th	death 3□	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
rds, P.O.	w requires that I been signed by should be deta	۵	Part II. Other significant conditions co.	ntributing to death but not resul	Iting in the u	nderlying cause give	en in Part I.		pacco use contribute to t	4
al Records,		Completed						24a. Was a autops perform	y prior to co	opsy findings available impletion of cause of
f Vital	ysician: is certifice director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA Oth		ath <i>(Check only on</i> Home 5 🐧 Reside	e) ence 6 ⊡Other (Speci	<b>(y</b> )
ion of	Attending Physician: r death. sctor: After this certifice by the funeral director, i		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe ho	ow injury occurred	
Division	P # 15 €	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or Rur n, State)	al Route Number,
	To the Hospital within 24 hours a To the Funaral completely filled	Medical		sician: To the best of my knowner: On the basis of examinati and manner stated.	on and/or in	vestigation, in my o	pinion, death occ	urred at the time, d	ate and place, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	R	_	29c. Licens	e number	2	9d. Date signed (Month,	Day, Year)
•	\		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print)	1,3 4)	5 J	C. A.	h 2006
	Sta Regist	ate rar	31. Date filed (Month, Pay, Year) SFP 1 8 20	32 Registrar's Signat	" A	este.	We h	are 1'C	IT NO CO	rung leng

			State	State of Marylan		rtment of H		Mental Hy	giene Reg. No. 2	006	29547
			Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. T	ime of Death
	Physicia		Day (1) 1/41	10 HAN				Se. 212	nbay 13	2006	1039 M
)	/Medic Examin		4a. Fecility Name (If not institution, give str	reet and number)		4b. City, Town, o	or Location of Dea		4c. County	of Death	7
	LXdiiiii	C1	Howard County Gener	cal Hospital		Columb	ia		How	ard	
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr		th ay, Year)	9. Birthplace ( Country)	State or Foreign
	Director		307 10 3010 1.	<sup>M 2□F</sup> 83	Yrs.			March	, 1923	Country) Wiscor	ısın
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. in	side City Limits
	Maryi f eho	ō	Maryland Howard	E	llicott	City				11	∐Yes 2. XTNo
	28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	38 o	ë	8511 Falls-Run Road	Apt. C		21043			U.S.A.		
	death	Funeral Director	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin?	(Specify Yes or No		ce - American Ind	Jian,
2	after or its		1 Never Married 2 Married	1 XYes 2 □ No		Yes 2 No			Specil		
3	ure!	d by	3 X Widowed 4 □ Divorced	Tear of Dates.		Iont's Havel Occur	notion.		16h Kind at B	Jusiness/Industry	
5	n 72	lete	15. Decedent's Educa (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of w d)	orking	16b. Kind of b	iusiriess/riuusiry	
7	withi iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		chemist			U.S.D	.A.	
2	be filed within 72 hours after death with the Maryland the Hygiene. At the Hygiene and other than "naturel", or iteme 23s or 28s-f show event, the Madical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden Sumai	me)	
ומות	should be filed within nd Mental Hygiene. marked other than imatic event, the We	To B	Scott A. Vaughan				Lillie	e Voelke			
9	2 should and Men is marke sumatic	. 4	19a. Informant's Name/Relationship (Type	•				Pural Route Numb			
<u>.</u>	and		Thomas J. O'Connel				k Road S	Suite 10			MD 21228
	Pages 1 nent of H int: If ital		20a. Method of Disposition  1 ★ Unit of Disposition  1 ★ Unit of Disposition  2 □ Cremation 3 □ Re	moval from State	cemetery, cren	sition (Name of natory or other pla		Date		- City or Town, S	
	Pag tmen tant:		4 □ Donation 5 □ Other (Specify)		1	l Cemeter		19/2006		ore, Mai	ryrand
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Paturet, or iteme 23e or 28e-f ehow any injury or other traumatic event, the Madical Examinat must be notified at MDEs.		21. Signature of Funeral Service Licenses	/ M00°				l Home, l ue Laure		land 20	0707
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	th. Do not ente	er the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,	Inter	roximate val Between
, 1	Physician		Immediate Cause (Final disease or condition	Atheresch	enotions	c Cari	24201	CULAR	DISPA	Se io	et and Death
ļ	/Medical		resulting in death)	Due to (or as a consec							1
	Examiner		Sequentially list conditions, b.								
_	ed isit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consec	quence or):						
12-	xecut and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):						
2/20	ficate be executed physicien and s the burial-transit	dical E	l d								
ĝ	certificate be nding physicie use as the bur	edic									
ŏ	h cert endin	N/N	230. was decedent pregnant	c. If yes, outcome of pregn 1□Live birth 2 □ Feta		Ectopic pregnanc	ev.			ate of delivery	V
-	death he atten ed for u	sicia	in the past 12 months?  1 Pes 2 No	4☐Pregnant at time of o		Other (specify)	, 		М	onth Day	Year
ب د	at the	by Physician/Me	9 Unknown'		outine in the	-dhi	una in Cart I	23e Did	tobacco uso con	ntribute to the cau	use of death?
S,	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant conditions cont	indusing to death but not re-	saking in the u	ndenying cause gi	veri in Faiti.		Yes 2 □ No	3 ☐ Probably	4 Nnknown
Ö	requ peen shoul	Completed						24a. Wa	245	Were autopsy fi	
Hecords	e las has	d						- auto	opsy ormed?	prior to complete death?	ion of cause of
VITA	ician: Th certificete rector, pag	e Co	25. Was case referred to medical				26 Place of C	1 ☐ Yes leath (Check only	2: No	1 Yes 2 1	No
	Physician: this certific ral director,	0 8	evaminer?	ospital:	] ER/Outpatien	nt 3 DOA Ot	bor	Home 5 Res		her (Specify)	
0	g Phys ler this neral di	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			how injury occu		
Ö	Attending in death.	atio	1 Accident 5 Pending investigation	(, 23, 132,	,,		Yes 2 □No				
DIVISION	spital or Attending Phous after death.  Nerel Director: After the filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci		eet, factory, office			(Street and Num own, State)	ber or Rural Rou	te Number,
_	pital ours a erel [		29a. Certifier 1 Certifying Physi	cian: To the best of my kn	owledge deat	h occurred at the t	me date and pla	ice, and due to the	cause(s) and m	anner as stated	
	• Hos 24 hc • Fun letely	edicai		er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	opinion, death oc	curred at the time	, date and place	, and due to the	æuse(s)
	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date sign	ed (Month, Day,	Year)
)	\		William Ho	wers, ms		020	0789		sup tem!	genlo, 2	006
	1541		30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type,	Print)		0.1	1	\	
			Will my Flowers	32 Pagintas	55 Li	TIE TAT	UXEAT	Colum	114 M	2	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 8	er: On the basis of my kn and manner stated.	J. J.	price					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 4.05 PM 2806 **Physician** WILLIAMS MARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore r if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ical Lenter 10W Genesis Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)

Yrs. If Under 1 Year Security Number 6. Sex **Funeral** Months Days 1□ M 2 PF 8 216-19-884 Usual Residence of Decedent Director 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Exercities must be notified at 1 ☐ Yes 2 No TOWSON Director Himore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 409 or Itams 23a Funerai permit. Pages 1 and 2 should be filled within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 100.8. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status UNK. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced lac Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Caundry Laborer UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Williams Herander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) busin 436 E. Penn 21286 40 OWSON delaine Date 20c. Location - City or Town State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Fbutus Mem Park 15/06 Arbuta 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility hatman -Harris Funricy Hom 21. Signature of Funeral Service Licenset 5240 Reisterstown ho Baltimore Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Month severe VD **Physician** /Medical **Examiner** Sta moritis End Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Moneto CVA attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.♥ Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Donknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes a No certificate 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? filled in by the funeral 27 Mannet of Death Certification: Diractor: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 SEPT 1 SUIH EIM D0053150 ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 SANTIAGO KD GUPTA ALEUNNAC

Registrar

State

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 124 **Physician** September 14 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Glen Burnie Anne Arundel 224 Wicklow Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Nov. 9, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Yrs 58 217 50 7728 1947 Maryland Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10a, State 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: if Item 27 is marked to ther than "naturel; or items 23a or 28a-1 show ury or other traumatic event, the Wallsel Examinar man be notified at 1 Tyes 2X No Glen Burnie Anne Arundel Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 224 Wicklow Road 21061 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Viet Nam 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Realtor Coldwell Banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Lillian Redmon George S. Wehn Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Wehn / Wife 224 Wicklow Road Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ☐ Cremation 3 ☐ Removal from State 1 🖫 Burial permit. Page Depertment of important: if eny injury or once. Baltimore, Maryland 9/18/2006 Cedar Hill Cemetery 4 Donati 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signs 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Part1. Enter the disea shock, or heart failure polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final **Physician** ac. disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ysicien and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete the Hospital or Attending Physician: After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2000 Certification; To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Accident Injury 5 ☐ Pending 2 □No death. 1 Tyes Al Director: A investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funaral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier VXI who completed cause of death (Item 23a) (Type 30. Name and address of person Print) NAG 32 registrar's Signature 31. Date filed (Month, Day, Yeer) State SEP 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, periff, G862, 12/12/06 TI Department of Health and Mental Hygiene

1- State Amend item#11, periff, G859, 9/18/06 TI Contificate of Death

Continued of Death 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SEPTEMBER 12 2006 WOLFSON 6:55 ABRAHAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY BALTIMORE 6410 ELRAY DRIVE APT. E If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. FEB. 4, 1919 5. Social Security Number **2805** 6. Sex 276-18-<del>2804</del> 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F OHIO 87 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1√⊒Yes 2 □ No MD Director BALTIMORE n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6410 ELRAY DRIVE APT. E 21209 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married filed within 72 hours after WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify. þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MAIL TRANSPORTER U.S. POSTAL SERVICE 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I Pages 1 and 2 should be WOLFSON **JOSEPH** ETHEL ROVNITZSKY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 165 WEST 66th STREET APT 6-G - NEW YORK, N.Y 10023 REGINA RESNICK / NIECE Health Item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛱 Burial 2 □ Cremation 3 □ Removal from State 5 permit. Page Department of Important: If any injury or once. BETH EL MEMORIAL PARK 09/15/2006 RANDALLSTOWN, MD 4 Donation 5 □ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FIBRILLATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dus to for as a consequence of) n any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit The law requires thet the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760. Physician/Medical nding I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy atten for u Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown ed by the Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed? 1 Yes 2 No or Attending Physiclan: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending 1 Natural death. investigation 2☐ Accident Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21218 KHOSLA 390/ THE ALAMEDA, MD Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 8 2006

DHMH 17 Rev 1/2001

Registrar

		1	For State	State of Maryland /	Department of Health and N Certificate of Death	lental Hygiene Reg. No	2006 29551
			Registrer  Decedent's Name (First, Middle, Las		oonmode or boarn	2. Date of Death	3. Time of Death
	Physicia	ın	feache 1/a	Whi	ite	Sept. 15.	2006 9:00 A M
	/Medic Examin		a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death
	*			nship Court	birthday) If Under 1 Year If Under 24 Hrs.		Baltimore Contact Foreign
	Funeral	60	5. Social Security Number 6. S	ex 7. Age (In yrs. last i	birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year,	
	Director	4	214-44-Z530 Usual Residence of Decedent			22/10 6, 1	145 Mary and
	yland now	-	10a. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits 1    Yes 2 □ No
	e-fsh	ctor	Mary land Baltin	rere Owi	ngs Mills		
	or 28	Dire	10e. Street and Number	, 0 /	10f. Zip Code		nited States
	s 23s	rai	54 Champiers h	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
	ter de	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1  Yes 2  No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
936	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28e-f show thet, the Medical Erand or must be notified at	þ	3 ₩idowed 4 Divorced	If Yes, Give // Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
5 0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		<ol> <li>Decedent's Usual Occupation         (Give kind of work done during most of work life. DO NOT use retired)     </li> </ol>	ring	Kind of Business/Industry
21215-0036	within ne. hen	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	Beautician		achalla Beauty Salen
р Б	filed withi Hygiene. other then		17. Father's Name (First, Middle, Last,		18. Mother's Nam	e (First, Middle, Maide	
an	should be and Mental s marked o umetic eve	To Be	John Hook	ins	Prache	iia M	ellins
Maryland	2 should be and Mental is marked (		19a. Informant's Name/Relationip (	Type, Print)	19b. Mailing Address (Street and Number or Ru	A	Control of the contro
	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "naturel; or Items 23a or 28e-f show or other treumetic event, the Medical Erandrat must be notified at	1	Tanaya Whi	te Jan 1	of Champion ship Ct	Date 200.1	Location - City or Town, State
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1: ☐Burial 2 ☐ Cremation 3 ☐	i come	e of Disposition (Name of etery, crematory or other place)		1 11 2
ţ	tment tant:		'4 □Donation 5 □ Other (Special		THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	18, 2606 B	altimore MD
Bal	permit, Pages Department of Important: If i eny injury or o		21. Sign turn of Funeral Service Lice	alter	PERSON L. WI	1 Bilto	F.S., P.A.
			23a. Part1. Enter the disease, or com	aplications that caused the death. (	Do not enter the mode of dying, such as cardiad		Approximate Interval Between
	Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Gall Ring	lder Concer		Onset and Death
	/Medical		resulting in death)	a Due to (or as a consequen			
8	Examiner		Sequentially list conditions,	b			
	pe is	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice or):		
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequen	nce of):		
8760	death certificate be executed e attending physician and ed for use as the burial-transit	dicai E	(	d			
9	tificate to oppose	Medi	IS SEEVALE.				
Box	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	eath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
O. E	the at	/sici	1 ☐ Yes 2 ♣ No 9 ☐ Unknown	4□Pregnant at time of deat 9□Unknown	th 5 🗆 Other (specify)		
۵.	The law requires that the de ate has been signed by the a page 2 should be detached f			contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	uires tha signed Id be del	d by				1 🗆 Yes	2 No 3 Probably 4 Unknown
Record	w requir s been si should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re	The la te has	dmo				performed?	death?
Vital	sicien: The law certificate has k irector, page 2 s	BeC	25. Was case referred to medical examiner?			ath Check onl one	
of V	Physicien: rthis certific ral director,	To E	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF			
o u	ing Pl		27. Manner of Death  Natural 5 Pending  Colored investigate	(Month, Day Year)	8b. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
isio	Attending ir death. ector: Afte by the fune	cat	3 ☐ Suicide 6 ☐ Could not	be ge Bless of lainer. At hom			and Number or Rural Route Number,
Division	after Direct	Certification:	4 Homicide determine	building, etc. (Specify)		City or Town, Sta	110)
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying F	Physician: To the best of my knowledge	edge, death occurred at the time, date and plac in and/or investigation, in my opinion, death occ	e, and due to the cause	(s) and manner as stated.
	he Ho in 24 he Fu	Medical	one)	and manner stated.			Date signed (Month, Day, Year)
	To the within 24	Σ	29b. Signature and title of certifier	enlan unh	29c. License number	G	1 . 5 . 5 . 1 . 1
•			- faire or	THE POLICE	V/0>07	2	ept 17 2006 MD 21229
	,		30. Name and address of person wh	o completed cause of death (Item)	otan Ave Rol	timere	MD 21229
	S	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatur	re	111111	
	Regis		SEP 1 8 20	106 Kenery J.	Sparte		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 29552 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Sept. Physician 5:07 PM 04 Tommie Ward 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year)

Months Days Hours Min. June 8, 19 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2対F Yrs. 81 Georgia Director 252-42-5418 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d, Inside City Limits 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Mudical Examinational be incitined at 1 Yes 2 No Director MD Prince Georges's Rowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20716 USA 12903 Clearfield Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Teal ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Carlie Ward/son 37790 Indian Creek Road Charlotte Hall, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If its any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 M Other (Specify) in state 21. Signa pre of Loneral Service I State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinoma of Physician /Medical Due to (or as a consequence of): Examiner Res Piratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner attending physicien and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 20 No certificate 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Euneral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 915,06 D0032761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9470 aurapolis Rd., Suito 418, Lanham, MD. 20706 Daee 31. Date filed (Month, Day, Year) State 2006 Registrar

			For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of Heat tificate of De	alth and Mental F eath	lygiene Reg. No	20	06	29553
	Physici /Medic	an al	10 10 F	EE )	Karbor	4b. City, Town, or Lo		embe	10	Year 2006	3. Time of Death
	Funeral Director		4a. Facility Name (If not institution, give the prints of	X Age (in )	rs. last birthday) 51 Yrs.  City, Town or Lo	If Under 1 Year If Months Days I	ore	Birth Day, Year)	,	9. Birthpla Countr Tenne	ace (State or Foreign y) SSEE  d. Inside City Limits 1 2 Yes 2 \( \) No
	with the Mi 3a or 28a-1	i Directo	10e. Street and Number 6526 Eastbourne A			10f. Zip Code	1224	-		/hat Countr	ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow empty injury or other traumatic event, the Medical Examples institled at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  12 Yes 2 No 1f Yes, Give 196 Year or Dates:	5–71	f Yes, specify Cuban, I	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc.) Specify:	No-	Black	American k, White, et White	tc.
21215-0036	d within 72 ho plene. r than "natur the Mudical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) Cotlege (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during the NOT use retired)  R Driver	n ing most of working		ind of Bus	siness/Indu	istry
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Maryland	nd 2 shou sith and N 27 is mai		19a. Informant's Name/Relationship (7 Towanda Yarbor/ W			•	Number or Rural Route Number Avenue, Balt				
Baltimore,	Pages 1 and of Her Int: If item		20a. Method of Disposition 1 ঐBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State C	b. Place of Dispo rownsv11 Cemetery	Ie Veteran	Sept. 15			City or Tow	
Balti	permit. Departn Importe eny Inju		21 Signature of Funeral Service Licen	ende			of Facility Rendon-Ba Limore Street,	_			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Right Ly Due to (or as a con	death. Do not ent		such as cardiac or respirator	y arrest,		1	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or a a conduction of a conduction).							
.O. Box 68	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)		-	23d. Date Mon	e of delivery	y Day Year
<u>α</u>	S C 0	<u>م</u>	Part II. Other significant conditions of		0 1		San de la lace			ibute to the	e cause of death?
Vital Records,	The law ete has b page 2 si	Completed		our Conges	. 41	art Failu	24a. W	utopsy erformed?	p	rior to com	sy findings avaitable pletion of cause of
Z:	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: Inpatient	2 ER/Outpatier	Other	<ol> <li>Place of Death (Check on</li> <li>Vursing Home 5 R</li> </ol>		€ □Oth	or /Spacific	
Division of	ding After fune	1	27. Manner ofeath   1 Natural   5	28a. Sate of Injury (Month, Day Yea	28b. Time o	28c. Injury at Work?					
Divis	al or Atte s after de el Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp		eet, factory, office		n (Street a Town, Stati		er or Rural	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2   Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, deat nination and/or in	vestigation, in my opin	date and place, and due to	he cause(s ne, date an	) and mar d place, a	nner as sta and due to t	ted. the cause(s)
)	To the within 2 To the comple	Σ	29b. Signature and Tie of certifier	Lemm.	Mo	29c. License n	_ 000	29d. Da	ite signed Hemb	(Month, D	ay, Year)
	2 Sta Regist	ate rar	30. Name and address of person who of the state of the st	32 Hegistrar's S	(Item 23a) (Type,	Print) m Avenue,	-000 Baltimore, 12	00 (1)	noryl	and).	21224
	* * L		SEP I O ZOO	The Contract	1	1					

DHMH 17 Rev 1/2001

06-06863 George Young Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 29554 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Y September 11, 2006 1601 hrs Young Medical Examiner George 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University Hospital NA If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 7. Age (In yrs last birthday) 5 Social Security Number 6 Sex **Funeral** Foreign Months Davs Hours 11-05-1982 Director Country) Md. 1 XM 2 23 215-08-8257 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State any 1 X Yes 2 No or 28a-f show Baltimore NA notified at once. Md. Director 10f. Zip Code 10g Citizen of What Country 10e Street and Number USA 21205 3103 E. Monument Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Funeral 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No SpeciBlack Divorced f Yes, Give Year 1 Yes 2X No specify: 'natural", ⋧ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) nut Pages I and 2 should be filed within 721 outment of Health and Mental Hygiene nortant: If item 27 is marked other than "nry or other traumatic recommend. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 NA Unemployed llth grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Davis Be Henrt Young, Jr. Shirley 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 3026 E. Monument Street, Baltimore, Md. Vivian Davis Grandmother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State 9-18-06 Lansdowne, Md. Zion Cem. Donation 5 Other Specify 22 Name and Address of Facility 21 Signature of Funeral Service Licensee March F.H. East 21202 1101 E. North Ave., Baltimore, Md. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease, of Physician failure. List only one cause on each line Between Onset and /Medical Death a Gunshot wounds (2) of left arm and torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23d Date of delivery ending phys use as the bi 23c If yes outcome of pregnancy 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? Records, P.O. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✓ Yes No 26 Place of Death (Check only one) Fo the Hospital or Amending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other<sub>4</sub> DOA 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other Inpatient 1 V Yes After t 28d Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Sep 11, 2006 Subject shot Natural 1528 hrs 1 Yes 2 ✔ No after death Director: 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 1102 Cleveland Street, Baltimore, MD (Specify) Local Street 4 V Homicide To the Funeral 29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie September 12, 2006 O.C.M.E. 30. Name and address of person v completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela Southall, MD 32. Registrar's Signature 31 Date filed (Month, Day, Year) State Registrar

		1	For State Registrar	State of Mary				ealth and Death	R	eg. No.	2006	
	sician ledical	ı	. Decedent's Name (First, Middle, Last Santo Vincent						2. Date of Dea Month SEP	Day	Year 2006	3. Time of Death
	miner	4		ospital		B	alti	Location of Dea			County of Death	
Fune Direc			Social Security Number 6. Se 220-82-0188	x 7. Age (// ₹M 2□F 42	yrs. last birthday) Yrs.		er 1 Year Days	If Under 24 Hr Hours Mir				place (State or Foreign ntry) 1and
n the Maryland	rector	1	Oa. State  10b. County  Maryland  Oe. Street and Number		Dc. City, Town or Lo	!	ip Code		1	0g. Citiz	en of What Cou	10d. Inside City Limits 1 ☑ Yes 2 ☐ No ntry?
Fre, Maryland 21215-0036  The stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 to marked other than "natural; or iteme 23a or 28e-f show	by Funeral Directo		960 Fell Street  1. Maritat Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	Unit 313  12. Was Decedent Eve Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Dec If Yes, sp	1231 edent of Hi ecify Cuba 2図 No		Specify Yes or No- into Rican, etc.)		4. Race - Ameri Black, White,	
21215-0036 within 72 hours aff	Completed		15. Decedent's Edic (Specify only highest grad			kind of w DO NOT	ork done o use retired	ation furing most of wi			d of Business/in	·
Maryland 2121 and 2 should be filed within Ith and Mental Hygiene.	To Be Co	1	7. Father's Name (First, Middle, Last) Vincent A. Alasci	o, Sr.	bneec	. He c	ar ne	18. Mother's Na	n Wess			ug
Iltimo	any in ury or other treuma	2	19a. Informant's Name/Relationship (T) Debra S. Alascio 20a. Method of Disposition 1 Burial 2 (Acremation 3 Di 4 Donation 5 Other (Specify, 21. Signature of Juneral Service Licens	Wifi Removal from State	Ee 960 20b. Place of Disposemetery, cre Metro Cr	Fell osition (No matory or emato 2. Name a Fune	Stre ame of other place ory and Addres ral H	et Unit 9/18 s of FacilitySt	8/2006 erling As	timo 20c. Loc Cato hton	ne MI) nation - City or T nsville Schwab	21231 own, State , MD Witzke
Physic /Medi Exami	ourial-transit		23a. Part . Enter the disease, or composhock, or heart failure. List only of the control of the	ne cause on each line.	sed blee onsequence of):  Stage onsequence of):	1630 iter the mo	Edmo ade of dyin	ndson A	venue; Ca ac or respiratory arr	tons	ville,	MD 21228 Approximate Interval Between Onset and Death HOURS
Box 6	tor use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetat déath 3	⊒Ectopic ⊒ Other (s	pregnancy specify)			23	3d. Date of deliv	ery Day Year
cords, P.O. wrequires that the deben signed by the	<u>\$</u>	1	Part II. Other significant conditions co Hepatic			underlying	cause give	en in Part I.			e contribute to t	he cause of death?
I Re la The la ete hes	page 2	-	Hepatic Thromboo Renal f						24a. Was a autops perfore 1 Yes	iv	24b. Were auto prior to co death? 1 \( \subseteq Yes	opsy findings available impletion of cause of
of Vital F Physicien: Th	Be Be		25. Was case referred to medical examiner?	Hospital:			Othe	)C	eath (Check only or			
Division of Vital Records,  To the Hospital or Attending Physicien: The law requires to within 24 hours after death.  To the Funeral Director: After this certificate hes been signed.	he tuneral dire	1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 Impatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatie 28b. Time of this this this control of the control o		28c. Injury Work	4 U Nursing	Home 5 Reside			(fy)
DIVI:	illed in by the tuneral		3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	Specify)				City or Town	7, State)		al Route Number,
the Hosp nin 24 hou the Fune	Medical		(Check only 2 Medical Exam one)	sician: To the best of miner: On the basis of ex and manner stated	amination and/or in	rvestigatio	d at the time on, in my op oc. License	pinion, death occ	curred at the time, d	ate and	place, and due t	o the cause(s)
To With	00		29b. Signature and title of certifier  Ramet				_	7602			signed (Month,	
-	U		1411.	900S CATO	INS AVE	R	ALTI	MORE	21229			
Re	State gistrar		31. Date filed (Month, Day, Year)	32. Brajistrar's	Signature	1	-					

SANTO

		-	For State Registrar	State of Ma	aryland /		rtment of H			giene Reg. No. 2 (	106	29556
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Sas	"Artisd	Ale	>			2. Date of De. Month	188	Year 2006	3. Time of Death
	Examin	er	Facility Name (If not institution, give	15 Hay	O( A	pirth day)	If Under 1 Year	Location of Dea	(P)	4c. County		lace (State or Foreign
	Funeral Director			м 2 <b>ХДУ</b>	91	Yrs.	Months Days	Hours Min		v. Year)	Coun	VA
	e Marylan la-f show	ctor	10a. State 10b. County MD		10c. City, To	wn or Loca LTIM					1	0d. Inside City Limits 1 XYes 2 □ No
	with th	Funeral Director	10e. Street and Number 3800 NORFOLK A	A VA EVATITE .			10f. Zip Code	216		10g. Citizen of	What Coun	try?
	death ms 23	eral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba		Specify Yes or No		ce - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic avent, the Modical Exaction must be coulded at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1	Yes, specify Cubai	n, Mexican, Pue	rto Rican, etc.)	Specil	ck, White, by: BL	etc. ACK
5-0	"natu	letec	15. Decedent's Ed (Specify only highest gra		16	(Give k	ent's Usual Occupa and of work done of ONOT use retired	luring most of wo	orking	16b. Kind of B	usiness/Inc	dustry
212	d within	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		MESTIC	, 		HOUSE	WORK	
	be file ital Hyg d othe avent,	Be	17. Father's Name (First, Middle, Last) WOODSON HUBBAI	OD.					me (First, Middle, LLIE HU		ne)	
Maryland	should ind Men s marke umatic	2	19a. Informant's Name/Relationship (7		15	9b. Mailing	Address (Street a				, State, Zip	Code)
	and 2 salth a n 27 is		LOUISE GOODE/	NIECE			3 LEEWO	OD AVE				21228
Baltimore,	Pages 1 nent of He int: If Itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cem et	tery, crema	ition (Name of atory or other place C MEM D		Date	20c. Location	•	
Ħ	nit. Pa entmer ortant Injury		4 □Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		ARE		Name and Addres	1	-23-06 AMES A.	BALTI		, MD SONS F.H.
<u>~</u>	permit. Depertr Imports any Inj		James a.	mart	m	1	701-31	LAUREN	S ST.	BALTIM	ORE,	MD 21217
			23a. Papt. Enter the disease, or companies shock, or heart failure. List only	lications that caused one cause on each lin	the death. Do	o not ente	r the mode of dying	g, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. A Due to lot as	a consequenc	ANG.	TALL	ure				4 days
	Examiner		Sequentially list conditions,	MASS	149	P	eeral	Z(+	010	M		
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dos to (or as	a consequenc	e of):	Linn					
Ο Ω.	ate be executed hysiclen and the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequenc	e of):						
8760,	icate be physicl s the bu	dical		d			_					
P.O. Box 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		,			
	es that igned b be deta	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the und	derlying cause give	en in Part I.				e cause of death?
Records,	v requ	eted	Matrita		41 1		70		24a. Was	-		ably 4 Allaknown  psy findings available
al Re	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detached.	Completed		1 (014					autor perfo 1 ☐ Yes	rmed? 2 No	prior to con death?	npletion of cause of 2 No
Division of Vital	ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	nt 2 ER/	Outpatient	3□ DOA Othe	20	eath (Check only only only only only only only only		ner (Specify	<i>(</i> )
<u> </u>	ing Ph Mer thi		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b y Year)	. Time of Injury	28c. Injury Work	at		now injury occur		,
isio	Attending ir deeth. ector: After by the fune	licati	2 Accident investigation 3 Suicide 6 Could not be determined		ury - At home.	farm. stre		Yes 2 □ No	28f. Location (	Street and Num	ber or Rura	I Route Number,
<u>&gt;</u>	tel or trs after sel Dire	Certification:	4   HOMICIO	building, et	c. (Specify)				City or Tou	vn, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after deeth. To the Funers! Director: After this certificate has completely filled in by the funeral director, page 2:	edical	29a. Certifier 1 Gertifying Ph (Check only 2 Medical Examone)	ysician: To the best niner: On the basis of and manner sta	examination a	lge, death and/or inve	estigation, in my op	oinion, death occ	e, and due to the curred at the time,	date and place,	and due to	the cause(s)
)	To I To I	M	29b. Signature and attle of certifier	1 Lee	n Se	00	29c. License	17(6	3	29d. Date signe	Month, I	Day, Year)
	le		30. Name and address of purson who	completed cause of d	eath (Item 23a	(Type, P	Print)	201 - U.S	Han	tala	CR	Himos
	Sta		31. Date filed (Month, Day, Year)	1 11	ar's Signature	Son Son	alle)		7	1 1/1/ 2		
	Registr	ar	SEP 1 9 20	06 Blace	es 15°	July 1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

		-	For State	State of Marylai	nd / Depa	artment of F	lealth and M			6 29557
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	lineale of		Reg. N 2. Date of Death	lo.	3. Time of Death
	Physicia	n	1111111111	VNETTE	Bu	RROWS		Month E	ay Year	639AM
	/Medic Examin		4a. Facility Name (If not institution, give	- /	Nu		r Location of Death	September	lc. County of Dea	th
	LXaiiiii		6502 Laurel	ton Avenue	e	Batti	more		N	IA
	Funeral		Social Security Number     6. September	7. Age (In yrs	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Mogth, Day, Yea	9. Bir	thplace (State or Foreign ountry)
	Director		216-19-0911	M 2 3 F 4	Yrs.			NOV. 27,1	960 CA.	LIFORNIA
	and	}	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryl	ò	MARWAID N	10		BAI	TIMOR	E CITI	/	1XYes 2□No
	r 28a	rec	10e. Street and Number	A		10f. Zip Code	111010		Citizen of What C	ountry?
	h with	0	6502/AURA	=LTON AVE	NUF		2121	4 '	1151	4.
	deat	Funerai Director	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto F	city Yes or No-	14. Race - Ame Black, Whi	
36	or it	Y.	1 Never Married 2 Married	1 ☐ Yes 2 ☑No If Yes, Give		1 ☐ Yes 2 No	Specify:		Specify:	C A O W
5-0036	72 hours after death with the Maryland neture!; or items 23e or 28e-f ehow dical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	162 Dage	dent's Usual Occup	ation	105		ZACK
15	n 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retired	during most of working	g 165.	Kind of Business	)
2121	1 within jiene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	LOAN	COLLEC	TION OFF	ICER C	REDIT	UNION
	othe vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid	en Sumame)(M	N-UNKNOWN)
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "iraumatic event, the Mer	2	JAMES	E. U	)ILS	ON	ARSE	NIA		
lan	2 sho		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Rura	Route Number, City	or Town, State,	Zip Code)
	l and lealth im 27 her tr		11115	IS CHUSICAND	Place of Dispo	osition (Name of	IKELTON	HVE. 10	4LTTHORY	E, HD 21214
or or	it of the state of		20a. Method of Disposition  1, Burial 2 □ Cremation 3 □ F	lemoval from State	cemetery, crei	matory or other plac	(8)		Location - City or	wn, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mentat Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinat must be notified at once.		4 □ Donation 5 □ Other (Specify)  21. Sign ture of Funeral Service License		BUTUS	CEMET	ERY 09-2 ss of Facility 2140	0-06 At	RBUTUS	MARYLAND
Ba	permit. Departrimports eny inji		21. Signiture of Full Black Delvice Licent	010m	/ J. T	Scanb 4 F	7 [	/ //	0 1	2/2/7
			23a. Part1. Enter the disease, or compl	ications that caused the dea	ath. Do not ent	ter the mode of dyir			me Balt	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	+ - /		001140			Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):	ung C	ancer			may o 6
	Examiner			Pulnion	ary	Emboli	Sm			August 06
	₽ /=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quençe of :					C
	ecute and A trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
8760,	eath certificate be executed attending physicien and a for use as the burial-transit			Due to (or as a conse	equence or);					
687	phys s the	dicai		j						
Box (	that the death certific ed by the attending p detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr					23d. Date of de	livery
	death e atte	Icia	in the past 12 months? 1 ☐ Yes 2 Ø No	1 Live birth 2 Fet 4 Pregnant at time of		]Ectopic pregnancy ] Other (specify) _	<u>'</u>		Month	Day Year
P.0	t the	hys	9 Unknown	9□ Unknown						
	w requires that the been signed by the should be detache	Dy.	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.			o the cause of death?
ord	equir sen s hould	ted	Diabello T	ghe 2				1 🗆 Yes	2 ∐No 3 ∏ P	robably 4 Honknown
ec	> 0 0	npie						24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
E	: The	ပ္ပ						performed?	vo 1 ☐ Yes	s 2□ No
Vit;	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		at all DOA Off	26. Place of Death			
o	Phys r this ral di	<u>ا</u>	1 Yes 2 No	1 _ Inpatient 2L	ER/Outpatier 28b. Time o	" 3L DOA	4 Linuising non	e 5 PResidence 8d. Describe how in		ocify)
o	ding th. : Afte	ţ	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □No		,,	
Division of Vital Records,	Atter r dea ector by the	Hica	3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, tarm, st	reet, factory, office	2	8f. Location (Street		ural Route Number,
	s afte	Certification:	4 Brothicide	building, etc. (Spec	ary)			City or Town, Sta	119)	
	To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funersi Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin	nowledge, deat	h occurred at the tir	ne, date and place, a	nd due to the cause	(s) and manner a	s stated.
	the hin 24	Medicai	one)	and manner stated.		29c. Licens				``
	Co. Twit		29b. Signature and title of certifier	6. 8		250. Licens	00 E Sn	_	Date signed (Moni	
	X		30. Name and address of person who co	ompleted course of death (he	am 23a) (T	Print)	10000	/	1-10-6	40.21218
	1		KAN 1 1 A KA	LPA 70	7. C	33145	7. # (	flod B	147-7)	2021218
	Sta	te	31. Date filed (Month, Day, Year)	32. Signstrar's Sign	nature.	P TO S			1010	10-
	Old		SEP 1 9 20							

DHMH 17 Rev 1/2001

Lillian L. Burrows

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AMEND ITEM#5 perfff, 889,9/22/06,WS

State of Maryland Department of Health and Mental Hygiene

1- For Amend PI, interval, perff , goo, 10/12/06

Registrar

Reg. No. 2006 Reg. No 2006 Month 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day **Physician** Ellsworth Bouyer 08:50 A M HArold 6 2006 SPT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHimure VA medical Center Altimure Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 24a2Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Days Hours 1 3 M 2 ☐ F 12 42-3348 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f show traumatic evant, the Medical Exertiner must be notified at 1 XYes 2 ☐ No Director MARVLAND 10g. Citizen of What Country? 10e. Street and Number DGEWOOD STREET Itams 23a Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 Is markad other than ' Elementary/Secondary (0-12) College (1-4or 5+) HVAC MAINTENANCE MECHANK 2 HAGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KAYMOND 2 19a. Inform. t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLEN BURNIE MD21060 2 other Place of Disposition (Name of cemetery, crematory or other place) Daté 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 ROWNSVILLE CEME, 09-21-06 CROWNSVILLE, injury \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign31 we of Fun ral Service JR. FUNERA any ir N. FULTONAVE, BALTO. Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician LANCER una /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or line) Due to (or as a consequence of): Examiner burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): sician Box 68760 Completed by Physician/Medical as IF FEMALE: should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) O 9□ Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after dea....al Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral L completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P18547 Sept 16, 2006 address of person who com pleted cause of death (Item 23a) (Type, Print) breene St. Baltimore, mi) 21201 32. gistrar's Signature State SEP 19 2006 Registrar

DHMH 17 Rev 1/2001

		•	For Amend item#17,pe	State of Maryland 1	Depa Cen	rtment of Heal	th and Me a <i>th</i>	ntal Hygie	ne 2006	29559
E	Physicia		Decedent's Name (First, Middle, Last)     Donna	L.		Banks		Date of Death Mooth EMBER	1 <sup>3</sup> , 20ď6	3. Time of Death 11:38 A M
	/Medic Examin		4a. Facility Name (If not institution, give st. Saint Joseph Med	reet and number)		4b. City, Town, or Loca			4c. County of Deat Balti	h
	Funeral Director		213-90-2417	7. Age (In yrs. last	birthday) Yrs.		nder 24 Hrs. 8 urs Min.	Date of Birth (Month, Day, Y	ear) Co	hplace (State or Foreign untry)  Md.
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Loc	ation				10d. Inside City Limits
	Mary n-f sh	to	Md. NA	В	altin	ore				1 X Yes 2 ☐ No
	ith the	Direc	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	sath w	eral	2903 Erdman Ave.	2. Was Decedent Ever in U.S.	12 14	21213 /as Decedent of Hispani	io Origin? (Speci	fy Vas or No-	USA 14. Race - Ame	ncan Indian
39	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. Item 27 is marked other then "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Examinar must be notilied at	by Funeral Director	11. Marital Status  1  Never Married 2  Marned  3  Widowed 4  Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	lf lf	Yes, specify Cuban, Me	ecity:	can, etc.)	Black, White	
Maryland 21215-0036	72 hou natura	Completed	15. Decedent's Educa (Specify only highest grade	ation 1	6a. Deced	ent's Usual Occupation	most of working	16	b. Kind of Business/	Industry
21	vithin 7 ne. hen "r		Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)	inost of working			
2	Hygie Hygie ther t		12th grade 17. Father's Name (First, Middle, Last) Banks		Di	sabled 18. N	Mother's Name (i	First, Middle, Ma	NA iden Sumame)	
an	ild be fental rked o	To Be	Donald Barns				Gladys	Ber	nice Be	eamon
ary	2 should and N is mar		19a. Informant's Name/Relationship (Type	e, Print)		Address (Street and N		The state of the s		
	1 and 3 Health em 27 ther tr		Juanita B. Bruce	Aunt		The Alameda	a , Balt		Md. 21218 c. Location - City or	
5	nt of h		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re	moval from State	etery, crem	atory`or other place)	i	-		_
Baltimore,	permit. Pages 'Department of P Important: If ite any injury or of once.	1	4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenses		-	n. Park Name and Address of F	9-20-	rch F.H	Randallsto	JWII, FIG.
ã	Depa Impo any in		Deady 1	Varier)	110	1101 E. No				21202
	Pnysician /Medical Examiner	e	resulting in death)	RESPIRATORY  Due to (or as a consequen  CARDIAC ARRE  Due to (or as a consequen	FAIL ice of): :ST		ch as cardiac or r	respiratory arrest	. 5	Approximate Interval Batween Onset and Death WEEKS
8760,	death certificate be executed e attending physicien and and and for use as the burial-transit	dical Examiner	cause. Enter Underlying	MORBID OBESI  Due to (or as a consequen						EARS
.O. Box 6	death certi e attending od for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	quires that n signed b uld be deta	ρ	Part II. Other significant conditions cont	nbuting to death but not resultin	ng in the un	derlying cause given in I	Part I.	23e. Did tobac	1/	the cause of death?
Division of Vital Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed						24a. Was an autopsy performe	24b. Were au prior to death?	otopsy findings available completion of cause of
Vita	ysician: This certificate	Be C	25. Was case referred to medical examiner?	ospital:		Other	Place of Death (		a Flour (a	
on of	ling Ph After th funeral	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Outpatient  Time of Injury	3 DOA 28c. Injury at Work?  M 1 Yes	28	d. Describe how	ce 6 Other (Spe injury occurred	ciry)
Divisi	P # P =	Sertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	28	If. Location (Stree City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, da estigation, in my opinion	ate and place, an	d due to the cau dat the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier			29c. License num		290	. Date signed (Mont	h, Day, Year)
}	1		1 Goddy 1			DØØ6397	/4		9/14/	06
	5		30. Name and address of person who con IRMAN E SIDDIQI.			Print)  R DRIVE	TOUSON	I. MARVI	AND 2120	14
	Sta	te	IRMAN E SIDDIG!1, 31. Date filed (Month, Day, Year)	32. Registrar's Signature	ا الله	Caste 1	- mrrammi		- us assert - Section on Section 2	
	Regist	ar	SEP 1 9 20	JUb Marker A	S. P.					

			1 - For State Registrar	State of Maryland / I	Department of Healt Certificate of Dea		iene 2006	29560
	Physici	an.	Decedent's Name (First, Middle, Las	0	)	2. Date of Death	·	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Locat	Soptem tion of Death	4c. County of Death	0 1.51 am
	Examin Funeral	er	Maryland Gene 5. Social Security Number 6. S.	A Hosoital  7. Age (In yrs. last bit	Children 1 Year   If Under 1 Y	e City	9. Birth	place (State or Foreign
	Director		243-42-4365 1 Usual Residence of Decedent	JM 2× 12	Yrs. Months Days Hou	urs Min. (Month, Day, march &	1934 SMH	h Carolina
	Maryland -f ehow	tor	10a. State 10b. County	10c. City, Tow	mor Location Baltem	se		10d. Inside City Limits 1 ★Yes 2 No
	after death with the Marylan or Iteme 23a or 28a-f ehow runar must be notitized at	al Director	10e. Street and Number	vellen Are	10f. Zip Code 2/2	07	Og. Citizen of What Cou	intry?
980		by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanie If Yes, specify Cuban, Me: 1 ☐ Yes 2 No Spe	xican, Puerto Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0036	within 72 ene. then "na	Completed	15. Decedent's Ed (Specify only highest gra	ucation 16a de completed)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)		16b. Kind of Business/Ir Fank Square	len tospital
		To Be C	17. Father's Name (First, Middle, Last)	Houston		Nother's Name (First, Middle, N	faiden Sumame)	nan
Maryland	d 2 shouth and No. 7 is maintained	-	19a. Informant's Name Relationship (	/	30 Le welle	2	City or Town, State, Zi	
more,	Pages 1 an ment of Heal ant; If item 2 ury or other		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5  Other (Specific	Removal from State	of Disposition (Name of pry, crematory or other place)  Conclusion	THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN THE PERSON NAMED IN TH	20c. Location - City or To	own, State
Baltimor	permit. I Departm importa eny inju		21. Signature Service Licen		22. Name and Address of F	SOLLE HILLA	plane Bil	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	lications that caused the death. Do ne cause on each line.	not enter the mode of dying, suc	h as cardiac or respiratory arre		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (of as a consequence	of):	droma		
7	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	b. Due to (or as a consequence	of):	S. O. J.		
,09289	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a consequence	of):			
	ntificate ng phy s as the	Medical	IF FEMALE:	<u>.</u>				
.O. Box	law requires that the death certift as been signed by the ettending 2 should be deteched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)	·	23d. Date of deliv Month	rery Day Year
Ω.	quires that t n signed by uld be dete	þ	Part II. Other significant conditions o	intributing to death but not resulting i	in the underlying cause given in P		acco use contribute to t	
Records,	age h	Completed				24a. Was ar autopsy perform 1 ☐ Yes 2	y prior to co death?	opsy findings available ompletion of cause of
Vital	Physician; 'this certifica	Be	25. Was case referred to medical examiner?	Hospital:	Other	Place of Death (Check only one	7.	
õ	Phys r this ral du	7: To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	Nursing Home 5 Reside		fy)
Division	or Attending I ter death. Irector: After In by the funer	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes		reet and Number or Run	al Poute Number
Ω̈́	5 g g c		4 Homicide determined	building, etc. (Specify)		City or Town	, State)	
	e Hospitai 24 hours a e Funeral l letely filled	Medical		ysician: To the best of my knowledg ilner: On the basis of examination ar and manner stated.				
)	To the within 2 To the complete	Me	29b. Signature and mitte of certifier/	bloe MD	29c. License numl	ber 29	9.10,06	Day, Year)
	2		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)  Moy Li land	General H	isotal	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 Sparks	THAM!		

State of Maryland / Department of Health and Mental Hygiene 29561 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** September 15, 2006 5:00 PM M Shirley Jean Baker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6803 Beech Avenue Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. 8.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 69 Yrs Director 567-42-5234 09/27/1936 CA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itama 23a or 28e-f above other traumatic event, the Medical Examiner court be notified at 1 Yes 2 No Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 6803 Beech Avenue United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify Completed by Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and 2 should be Daniel D. Webster Mary Elizabeth Bruck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sue Ann Lankford/Daughter 6803 Beech Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sep 19 Beltsville, Maryland 5 ☐ Other (Specify) 2006 Chesapeake Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility M00984 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiovespirator **Physician** /Medical Due to (or as a consequence of): Examiner mentra Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) OPD ng physicien and as the burial-transit Exam Due to (or as a consequence of): Physician/Medical ettending i IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the ef 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 No 1 ☐ Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho To the Fund completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/18/06 D56466 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Compbell Blvd White Movsh ND21236 4924 1 SWAT 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2006 THE PART Registrar

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Maryland 2121

Division of Vital Records, P.O. Box 68760

Shirley Baltimore, [

06-06872 Simon Bautista Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Medical Examiner** SIMON LUIS BAUTISTA 2115 hrs September 11, 2006 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death c County of Death 7217 Paperback Trail Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) **Funeral** oreign Days Hours Director Country) Panama 098-46-1004 1**x** M 2 56 OCT. 6, 1949 Usual Residence of Decedent 10a. State 10c City, Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once. Yes 2 28a-f show MARYLAND PRINCE GEORGES LAUREL 10e Street and Numbe 10f. Zip Code 10g Citizen of What Country 7217 PAPERBARK TERRACE 20707 UNITED STATES AMERICA ē 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust he 14. Race - American Indian, Black or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married White, etc. Never Married 1 X Yes 3 Widowed 4 Divorced If Yes, Give Year 1X Yes 2 No specify PANAMA Specify: BLACK traumatic event, the Medical Examiner "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 LOAN OFFICER MORTGAGE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be JORGE BAUTISTA MINA BROWN 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE BAUTISTA/WIFE 7217 PAPERBARK TERRACE LAUREL MARYLAND 20707 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date Baltimore, t: If it crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: ARLINGTON NATIONAL CEM. 10/20/2006 ARLINGTON, VIRGINIA Donation 5 Other Specify 21 Sinat le f Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME 7601 SANDY SPRING ROAD Wan LAUREL MD 20707 ٤ 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a Aortic Dissection Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED ending physician use as the burial AMENDED death certificate be Box 68760 23c If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown q Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ ۵. 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✓ Yes No 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner? Hospital Inpatient 2 ER/Outpatient 3 DOANursing Home 5 this Residence 6 V Other Scene 2 1 V Yes No 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c Injury at Work? 28d Describe how injury occurred ✓ Natural 5 Pending Yes 2 No 1 Funeral Director: 2 Certificat Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day Year) O.C.M.E. September 12, 2006 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 29563 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Geraldine Bruce SEPTEMBER 13.2006 11:25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center Examiner Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May31, 1947 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🔀 F Maryland 210-46-7437 59 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County il Hygiene. other than "natural", or items 23s or 28s-f ehow vent, the Madical Exeminar mant be notified at 1 Yes 2 No Middle River Baltimore MD Director 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number USA 21220 27 Gyro Drive Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Franklin Square Elementary/Secondary (0·12) 1 2 t h College (1-4or 5+) Phlebotomist Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event pace. Genieve Arbutus William W. Bottomstone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27 Gyro Drive Baltimore MD 21220 Gary Bruce /husband 20b. Place of Disposition (Name of cometery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 9/16/06 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE **Physician** DECADES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physicien and The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 Yes 2 XNo
9 Unknown 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy
performed?

Yes 2 1 hes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28c. Injury at Work? ate of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Brinker MD 9/15/2006 D51852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A BRINKER, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2006

DHMH 17 Rev 1/2001

			State of Maryland / Dep 1- State Amend Item 21 per FH, G859	artment of Health and M 09/19/06dhb rtificate of Death	lental Hygiei	ne No. 2006	29564
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Hasker boozer		09	27 2006	22:48 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Johns Hopkins Boyview Medical Center	Battimer e	2.5 (5:1)		
	Funeral Director		5. Social Security Number  250-26-1110  6. Sex   7. Age (In yrs. last birthday,   180 M 2 F   84 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 01/08/19	9. Birthpi Count NC	ace (State or Foreign lry)
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10	d. Inside City Limits
	Mar Mar	tor	MD Balt	imore			1 XYes 2 ☐ No
	h with the 23a or 28	Funeral Director	10s. Street and Number 714 N. Hilton Street	10f. Zip Code 21229		Citizen of What Count	try?
980	be ilied within 72 hours after death with the Maryland ital Hygiene. Ind other then "naturel; or iteme 23a or 28a-f ehow event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 No Specify:	ecfy Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: <b>B1</b> .	
21215-0036	within 72 ho ene. then "natur he Medical	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation s kind of work done during most of working DO NOT use retired)	ng 16b	. Kind of Business/Ind	,
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Mar	and and me		. 1	ng Address (Street and Number or Rura 4 N. Hilton St.		•	
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Baltimore,	permit. Pag Depertment Important: eny injury o		Vaughn C. Greene per dyr V	2. Name and Address of Facility  Aughn C. Greene	Funera	1 Service	e
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	151 Baltimore Notes the mode of dying, such as cardiac of	Vational or respiratory arrest,	Pike,Ba	lto. MD Approximate
	Physician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. H3(V)  Due to (or as a consequence of):				gears
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	te be executed ysicien and ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
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rds	quires in sign uld be	Da Da	Renal insufficiency		1 🗌 Yes	2 No 3 Proba	bly 4 Unknown
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of Vital		Be C	25. Was case referred to medical examiner?	26. Place of Death		140 10165	E I NO
<u>}</u>	di is	70	1 Yes 2 No Hospital: 1 ☐ Inpatient 2 EP/Outpatie	nt 3 DOA Other: 4 Nursing Hor	ne 5 Residence	6 ☐Other (Specify,	)
	a fee	ation:	27. Manner of Death  1, Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)	of 28c Injury at Work?  M 1 Yes 2 No	28d. Describe how in	njury occurred	
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	Hoepil 4 hour Funer iely fill	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Certifying Physician: To the best of my knowledge, deal (Check only one)  Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ad at the time, date a	e(s) and manner as sta and place, and due to	ited. the cause(s)
)	To the within 2 To the complete	M	29b. Signature and title of certifier	29c. License number D 23 684	29d. 1	Date signed (Month, D	ay, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Type,	DZ8684 Print) Medical (	ander	10000	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	" Carlow C	y rope C		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 29565 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:32 PM 2006 eptember /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Hospita Center Northwes If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 08-15-5. Social Security Number 218-64-1283 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2**X**F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City Town 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? 23a or 1244 noac Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Itams 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 tf Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed)
(Specify (0-12) College ( 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b Kind of Business/Industry other than College (1-4or 5+) permit. Pages 1 and 2 should be filed w Depenment of Health and Mental Hygier Important: If Item 27 is marked other It sny injury or other traumatic event, the Once. Father's Name (First, Middle, Last) Mother's Name (First, Middle Be ဂ္ဂ Town, State, Zip Code) ant's Name/Relationship Fivee. 19b. Mailing Address (Street and Number 9a Infa Cousin Ustown, ND 21133 Date 20c Location - City or Town, State 20a. Method of Disposition Burial 2 3 Removal from State Cremation 5 ☐ Other (Specify) 21. Signature of Plan a Service Ligense llstown Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cardiopulmonary **Physician** Acute tailure /Medical Due to (or as a consequence of): Examiner robable Dulmonar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed ommunity acquired pheumoni Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No vilipidemia 2□ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 Ves 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown ospita Northwest Center gistrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2006 Registrar 1800

State of Maryland / Department of Health and Mental Hygiene 2 (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Marie Benda Baumiller Sept 2006 14. 5:45 /Medical a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 15, 1 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 2 F 216-03-4932 96 Sept Director 1909 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. tnside City Limits 28a-f ahow other than "natural", or Itema 23a or 28a-f ahov vent, the Mudical Examinar must be notified at MD 1 ☐ Yes 2√ No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 866 Sues Grove Rd. 21221 U.S.A. Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White δ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Sales Clerk Retail permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, I 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Joseph Benda Barbara Ann Vavra ္က 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Fitch/Daughter 866 Sues Grove Rd. Essex Md 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Buriat 2 XCremation 3 ☐ Removal from State West Arundel Crematory 9-18-2006 Odenton, Maryland Donation 5 ☐ Other (Specify) Signature of Euneral Service ice 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part. Enter the disease of comshock, or heart failure. List only emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Complications of Dementis 4 CWI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of detivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 Who
9 Unknown Month Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 Tyes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Ptace of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification; To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how intury occurred ne Hospitet or A...
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~eral Director: Afte 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 58303 September 14 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N Charles It Bapune mo 21204 31. Date filed (Month, Day, Year) CHAMIURS m 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20b c per fh g859 9-21-06 yt.
State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 29567 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4c. County of Peath POKINDER /Medical 4b. City, Town, or Location of Death (If not institution, give street and nu Examiner If Under 24 Hrs. Age (In yrs. last birthday)

Yrs. 5. Social 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Min. -525 1**0**X1M 2∏ F **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28e-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Be Completed by Funeral Director nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Drigin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced ac 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT, use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Importent: It Item 27 Ie marked other than 'sny injury or other traumatic event. In Ma 2002. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, mmon 19a. Informant's Name/Relationship (Type, Print) (niece) 19b. Mailing Address | Street and Number or Rural Route Number, City or Town, State, Zip Code) alto.11/1d.21208 ven en 20b. Phone of 20c. Location - City or Town, Slate Lansdowne Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours affer death.

To the Funerel Director: Affer this confirmed. signed by the attending physician and 5 be detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

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[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

legistrar's Signature

			State of Maryland / Dep 1 - State Amend #20b er FH G860 e	artment of Health and M Milicate of Death	lental Hygien	e 2006	29568
			Negistrar      Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
ı	Physicia /Medic		Paul	Boone	Month 09 14		6:45a. M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death	
			Future Care Nursing Care	Baltimore ) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	N/A	lace (State or Foreign
г	Funeral Director		5. Social Security Number  185-07-7889  6. Sex  10 M 2 F 7. Age (In yrs. last birthday, Yrs.	Months Days Hours Min.	(Month, Day, Yea)	17 Cour	NC
			Usual Residence of Decedent		00 20		
	arylan show	_	10a. State 10b. County 10c. City, Town or L			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-1	Director	MD NA Baltimo		100.0	Citizen of What Cour	
	with t	Dir	10e. Street and Number 3109 Chelsea Terrace	10f. Zip Code 21216	109. 0	U.S.A.	
	ns 23	Funeral		Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
9	or Itan		Armed Forces?  1 Never Married Married If Yes, 2 M No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Black, White,  Specify: R1	
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2	filed within 72 hours after death with the Maryland Hygiene. nther than "natural", or Itams 23a or 28a-f show ant, Ita Medical Examinar must be notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work: DO NOT use retired)		Kind of Business/In	dustry
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<u>Xai</u>	should be and Mental s markad o umatic sva	ToE	Daniel Boone		atthews		!
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e,	1 and Health am 27		20a Method of Disposition 20b. Place of Disp	O Chelsea Terra		Location - City or To	
more, Maryland 21215-0036	Pages nent of H ant: If its ury or of		152 Rurial 21 ICromation 31 Hemoval from State	omatory or other place) 9/19 on Forest Vet. 5	· Fire	Owings M	ills, Md
=	permit. Pages 1 and 2 of Department of Health ar Important: If itam 27 is any injury or other trauone.		21 - 1707 Land of Funeral Service Licensee	22. Name and Address of Facility March F/H West			
Ba	Ped Im B		1 Provide C. Tainet	4300 Wabash Ave		ore, Md	21215
H			23a. P. rt1. Enter the disease, or complications that caused the death. Do not endock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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8760,		by Physician/Medical	d				
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Вох	death a atter	clar	In the past 12 months?  4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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S,	es tha igned be de	ру Р	Part ff. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to to 2 □ No 3 □ Prot	
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a	n: Th ficate or, pag		25. Was case referred to medical	De Diago of Dogs	1 ☐ Yes 2 🛂1 h (Check only one)	Vo 1 ☐ Yes	2 No
>	ysicia s cart direct	To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Others	ome 5 Residence	6 □Other (Special	y)
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sioi	tandir eath. tor: Ai	catle	2 Accident investigation	M 1 Yes 2 No	004 1		Control Manager
Division of Vital Records, P.O.	or At after d Diraci in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta		n Houte Number,
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	To tha Hospital or Attanding Physician: The law within 24 hours after death.  To the Funaral Diractor: After this certificate has been present itled in by the funeral director, page 2	edical	(Check only 2 Medical Examinar: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due to	o the cause(s)
	vithi To 1	Σ	29b. Signature and title of certifier	29c. License number	29d. 0	Date signed (Month,	Day, Year)
	. 7			Drint) A A	1 11 -	1- 1-	
4	7		DARCHAN S. SALUM 1600W. R	IQUAT Royal Are,	Isalto 2	121/	
	Sta Regist		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type DALLAN, S. ALVA 600 W. W. 31. Date filed (Month Pay, Year) 2006  33. Pagistran's Signal in Alvandaria (Month Pay, Year) 2006	7.000			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perMD, 8859 9/19/06 TT

State of Maryland / Department of Health and Mental Hygiene 2006 29569 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Wilette Bruce 2 Date of Death 3. Time of Death **Physician** August 25, 2006 1126 DM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner John Hopkins Bayview Medical Center HMOVE If Under 24 Hrs. 5. Social Security Number Age (In yrs, last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 E Days Min Hours 214-86-5120 40 Yrs. Md Director 10-26-1965 Usuat Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or itama 23a or 28a-f ehow the Medical Exeminer must be notified at 1 Ty Yes 2 ☐ No Director N/A Balto Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 238 21206 USA 5516 Whitwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married 10 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à Specify: Black. 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Cottege (1-4or 5+) Levindale Center Nursing Assistant 12th grade 17. Father's Name (First, Middle, Last) Destinit. Pages 1 and 2 should be file.
Deperment of Health and Manial Hygical important: If them 27 is marked afty injury or other 12. 18. Mother's Name (First, Middle, Maiden Surname) Willie Bruce Carolette Gilliam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolette Bruce - Mother 5217 Cedgate Road Balto, Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify) King Memorial Park | 9-2-2006 Randallstown, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or heart failure. List only one cause on each line. 4300 Wabash Avenue Balto, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUHONIA Physician 2 week /Medical Due to (or as a consequence of): **Examiner** Hodakin's
Due to (or a consequence of): lumphoma. frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien end the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical **SB BSD** IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown į Month Day 4 Pregnant at time of death 5 Other (specify) signed by the e P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۵ ate hes been signa page 2 should be INTRAVASCULAR COAGULATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No after deeth.

Diractor: After this certificate hes autopsy performed Division of Vital 2☐No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 2000 Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident М investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide filled in To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of contilier 29d. Date signed (Month, Day, Year) MO, PhO bhe ade RESOO! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALTSHA WADE, 4940 EASTERN

DHMH 17 Rev 1/2001

State

Registrar

AVENUE

31. Date filed (Month, Day, Year) SEP 1 9 2006

BALTIMORE

MD, 21224

32. Registrar's Signature

Bert Car

Amend Items 25,27,28a-f per MF C359,09/15/06dhb

State of Maryland / Department of Health and Mental Hygiene 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:30 a M August Physician Anna Theresa Blades 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Towson Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 6, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 200 F 79 Maryland Yrs. 212-20-8220 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No MD Baltimore Pikesville Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21208 U.S.A. 313 Upland Road death permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural" ~- " any injury or other traumatic even." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 AWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Giavanni Scardina Gennie Brocato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Loverde/Daughter 345 Tulip Oak Ct. Linthicum MD 21090 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Berial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Denation 5 ☐ Other (Specify) Cedar Hill Cemetery 8-16-2006 Glen Burnie, MD 21. Signature of Funeral Strvice Licenste Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Rard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GREDIA C /Medical Due to (or as a consequence of): Examiner discourse evenary arteru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed the burial-transit BA WESTON ENWINE attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 □Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð TrActive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peed: COPV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? nuritanal SINIUS 20012 1 Yes 2 No 1 Yes 2 No or Attending Physician: After this certific funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1x Yes 2 Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 04/11/2006 4:22 a M 1 Zisiaturai 5 Pending Subject fell Accident death. 1 ☐ Yes 2 ▼ No investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 345<sup>th</sup> Tulling Place Court MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home of relative** 4 Homicide within 24 hours a
To the Funerel C
completely filled 12. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31926 2/14/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 RQ attery. 32. Registrar Signature 31. Date filed (Month, Pay Year) State Registrar

		1	For State Registrar	State o	f Maryla	nd / Depa	artment of H	ealth and N Death		gienez	2006	29571
19.	÷.		Decedent's Name (First, Middle, La	ist)					2. Date of Dea	ith Day	Year	3. Time of Death
	sicia		Jane D. R. Campb	e11					Month Septemb			6 10:15 A <sup>M</sup>
	ledic: amine		a. Facility Name (If not institution, given		mber)		4b. City, Town, or	Location of Death			ounty of Dea	
			Springhouse at W	estwood			Bethesd				ntgome	-
Eune			, , , , , , , , , , , , , , , , , , , ,	Sex 1 □ M 2 <b>X</b> ) F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Da)	h /, Year)	C	rthplace (State or Foreign ountry)
→ Direct	ctor		104-10-0605 Usual Residence of Decedent		94	115.			March 2	23, 1	914 1	lew York
land	12	-	10a. State 10b. County		10c. 0	City, Town or Lo	cation					10d. Inside City Limits
Mary	3	ğ	Maryland Montgom	erv	Bet	thesda						1 ☐ Yes 2 📉 No
n the	The second	~	10e. Street and Number				10f. Zip Code			10g. Citize	en of What C	ountry?
h with	10	a D	5101 Ridge Field	Road			20816			U.S	.A.	
r dea	5	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in orces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	. 14	<ol> <li>Race - Am Black, Wh</li> </ol>	erican Indian, ite, etc.
s after	E	by Fr	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, G	ive -		1 ☐ Yes 2 🗓 No	Specify:		5	Specify: Wh	ite
hours	a Ex		15. Decedent's E	Year or E	Jates:	16a. Dece	dent's Usual Occup	ation			d of Busines:	
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withi withi jene.	E P	E O	Elementary/Secondary (0-12)	College (	1-40r 5+)	Sec	retary			C1e	rical	
othe othe	/sut	BeC	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	ne (First, Middle,	Maiden S	Sumame)	
uld by Menta	if c	To	Francis Dalton					Jane (	O'Neill			
Individual CILID-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itsma 23a or 28a-1 show	emme		19a. Informant's Name/Relationship				ng Address (Street				Town, State,	Zip Code)
and and n 27	ner tr		Ellen Kruse (Da	ughter)	- 100		Coach St.	, Potoma	C, MD 20 Date		ation City	- Town State
DESILITIOTE, MICE YIGHTO Z.I.Z.I.D.COOO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a or 28a-1 show	or of		20a. Method of Disposition 1    Burial 2 □ Cremation 3	☐Removal from		cemetery, crei	natory or other plac	(e)     0 / 2 2				r Town, State
Dallillor Dermit. Pages Department of mportant: If It	jury	1	4 Donation 5 Other (Spec		S		ick Cemet		_		or, NY	
Dermii Depar mpor	eny Ir		21. Signature of Funeral Service Lice	nsee			2. Name and Address Jarmusz C				<i>.</i> .	
- 40.5		-	23a, Part1. Enter the disease, or cor	nolications that	caused the de	eath. Do not ent	26 Maple	Ave., Vi	or respiratory ai	145 rest,	64	Approximate
	3		shock, or heart failure. List ont	y one cause on	each line.							Interval Between Onset and Death
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the de	ped f	/sic	in the past 12 months? 1 □ Yes 2 ❷ No 9 □ Unknown	4∐Preg 9□ Unki	nant at time o nown	of death 5L	Other (specify)					
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w require	shoul	Completed							24a. Was	an	24b. Were	autopsy findings available
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VITAL  Sicien: The	or, pa	ပို	25. Was case referred to medical		<del> </del>			26. Place of Dea		2 X No	1 U Y 6	es 2 No
OT VITA Physician: rthis certific	direct	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3□ DOA Oth		lome 5 Resi		Other (Sp	pecify)
g Phy er this	eral		27. Manner of Death	1	of Injury oth, Day Year,	28b. Time o	of 28c. Injur	y at	28d. Describe	how injury	occurred	
ath.	ne fun	atio	1 Natural 5 Pending investigat	on	m, bay roa,	,,		Yes 2 □No				
DIVISION C al or Attending P after death. I Director: After	by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 200. Flat	ce of Injury - A ding, etc. (Spe	t home, farm, st	reet, factory, office		28f Location ( City or To	Street and wn, State)	Number or	Rural Route Number,
ital o	letely filled in by the funeral director, page		37									
To the Hospital or within 24 hours af To the Funeral D	tely fi	Medical		aminer: On the			th occurred at the till exestigation, in my o					
thin 2	eldmo	Mec	29b. Signature and title of certifier	and ma	Tiller Stated.	1	29c. Licens	se number	T	29d. Date	signed (Mo	nth, Day, Year)
řšř	ŏ		> Much	20/1	1/2	alle	MD15	901		Sept	ember	15, 2006
	`		30. Name and address of person wh	o completed	use of death (I	Item 23a) (The				P -		
10	)		Michael Grady,	/ ·		201 00+	hadren 7 Arr	e. N.W. 1	Washingt	on,	DC 200	16
The same of	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Si	gnature	nediai Av					
Re	egistı	ar	\$EP 1 9 2	UUb A	Della .	No Pop						

		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of F	lealth and N <i>Death</i>	Mental Hyg	giene 20	06	29572	
Physic /Med		Decedent's Name (First, Middle, La     JOHN PATRIC	K CAPECCI,SR				2. Date of Dea Septem	ber 18	, 2006	3. Time of Death 6:02 AM	
Exami		4a. Facility Name (If not institution, gir Gilchrist Center	ve street and number)		4b. City, Town, o	r Locatio <i>n</i> of Death SON		4c. County	of Death	ore	
Funeral Director			Sex 7. Age (In yrs. I 1XM 2□ F 68	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Pay	1938	9. Birthpla Mary	ace (State or Foreign Land	
Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County MD Bal	timore 10c. City	, Town or Lo	cation Essex		1		10	d. Inside City Limits 1 ☐ Yes 2 ☐ No	
death with the Maryland ma 23e or 28e-f show rmust be notified at	al Director	10e. Street and Number 1603 Sandy H	ollow Circle	**	10f. Zip Code 21	221		10g. Citizen of V USA		ry?	
<u> </u>	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🖔 Divorced	12. Was Decedent Ever in U. Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race Blace Specify	e - America k, White, e Whi	tc.	
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mentel Hygiane. The marked other than "natural; or its traumatic avent, the Medical Examin	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		(Give	DO NOT use retired	during most of work	-	16b. Kind of Bu Bethler		-	
yland z	To Be C	17. Father's Name (First, Middle, Las John J. Capecc	•			18. Mother's Nam Helen	e (First, Middle, Healey	Maiden Sumam	re)		
Ma d 2 :: Than Trau		19a. Informant's Name/Relationship Bryan L. Capecci			-	and Number or Rui Road–Bal					
Page nent o ant: If ary or		20a. Method of Disposition  1 N Burial 2 Cremation 3 ( 4 Donation 5 Other (Special Control Con	Removal from State Gar	dens"	sition (Name of Patory of other place Etery		-06	Roseda.			
Baltim permit. Pag Department important: I any injury o		21. Signature of Funeral Service Lice	nsee	88	Name and Addre Harfo	ss of Facility FVA rd Road—F	NS CHAP arkville	EL OF MI	MORIE	FS34	
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):									
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8760, cate be executed physicien and the burial-transit	dical Ex	rosulary in oscilly Last	Due to (or as a consequent	Jence of):							
ecords, P.O. Box 6: law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Dat Mor	e of deliver	y Day Year	
rds, P.O. I quires that the de n signed by the a	<u>۾</u>	Part II. Other significant conditions	contributing to death but not rest	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		ibute to the	e cause of death?	
Of VItal HECOrds,  Physician: The law requires this certificate has been signs al director, page 2 should be o	Completed			<u>-</u>			24a. Was a autop perfor	med2   c	Were autoportion to combleath?	sy findings available pletion of cause of	
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DIVIS tal or Atte rs after de al Directo ed in by th	Certification:	3 Suicide 6 Could not 4 Homicide determined		me, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and Numb in, State)	er or Rural	Route Number,	
DIVISION To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filted in by the funer	Medical	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	vestigation, in my o	pinion, death occur	red at the time, o	date and place,	and due to t	the cause(s)	
Wilt Too	2	29b. Signature and title of certifier	my Riley	, uv	29c. Licens			Septen		2 (204	
6		30. Name and address of person who	completed cause of death (tyen)	670	Print) N-C	Charle.	St. i	Balti-	MI	21204	
Regis	_	SEP 1 9 200	6 Similar St	des	di)						

		1 - For State Registrar	itate of Maryland / Depa Cer	artment of Health and M rtificate of Death	lental Hygiene	ZUUN ZYN / 1
Physic		Negdatal     Necedent's Name (First, Middle, Last)     WASYL CZAN			2. Date of Death  Month  September	
/Med Exami		4a. Facility Name (If not institution, give stre Washington Advent:		4b. City, Town, or Location of Death Takoma Park		. County of Death Montgomery
Funera Director		5. Social Security Number 6. Sex	2□F 7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year II Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 14,	1917 Ukraine
DESIGNATION CO. MINITY STATES A SECURIOR PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY IN THE PROPERTY	To Be Completed by Funeral Director	Maryland Prince Ger  10e. Street and Number  4811 LaSalle Road  11. Marital Status  1 □ Never Married 2□ Married  3 ☒ Widowed 4 □ Divorced  15. Decedent's Educat (Specify only highest grade of the company (0-12) 12  17. Father's Name (First, Middle, Last)  Prokop Czan  19a. Informant's Name/Relationship (Type Michael Czan — So  20a. Method of Disposition  1 ☒ Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service vicensee	Was Decedent Ever in U.S.  Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:  ion completed)  College (1-4or 5+)  16a. Dece (Give Iffe.  Ga  Print)  19b. Mailli  7 31  20b. Place of Disp cemetery, cre Cedar H	Le 20782  Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerform of Work done during most of work and Number or Rule 1 Adelphi Road, Hostiton (Name of matory or other place)  111 Cemetery 09/0	ecify Yes or No-Rican, etc.)  ing  16b. F  e (First, Middle, Maider ulie Bagan al Route Number, City yattsville Date  200. L  29/2006 Su easch's Func	or Town, State, Zip Code) , Maryland 20783 .ocation - City or Town, State .itland, Maryland eral Home, P.A.
BOX 68/60, eath certificate be executed estending physicien and estending physicien and lor use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence of):  Public of the consequence of the con	Shock.	Penninal).	23d. Date of delivery
HECOTGS, P.O. The law requires that the d ste has been signed by the page 2 should be detached	Completed by Physician/Med	in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions control  Hurro Se	4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown ibuting to death but not resulting in the i	Other (specify)		Month Day Year  o use contribute to the cause of death?  2 🖾 No 3 🗆 Probably 4 🗀 Unknown  24b. Were autopsy lindings available prior to completion of cause of death?  1 🗀 Yes 2 🗀 No
VITZ sician certifia rector	Be	25. Was case referred to medical examiner?	spital: 1 5 Impatient 2 DER/Outpatie	Othor	th Check only one ome 5 Residence	6 DOther (Specific)
VISION Of VITAI HEC Attending Physician: The law or death. •ctor: Atter this certificate has by the funeral director, page 2	Certification; To	1 ☐ Yes 2 ☑ No  27. Mannenof Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how inj	ury occurred
DIVISION SITE OF Attentions after death well Director:	Certif	4 Homicide determined	28e. Place of Injury - At home, larm, s building, etc. (Specify)		City or Town, Sta	
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1	cian: To the best of my knowledge, dea or: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occurred at the time, date and place nvestigation, in my opinion, death occurred at the time, date and place nvestigation, in my opinion, death occurred at the time, date and place nvestigation of the time of the time, date and time of the time of time of the time of the time of time of the time of time o	rred at the time, date a	s) and manner as stated.  Indiplace, and due to the cause(s)  Date signed (Month, Day, Year)
T with		> Lace of At	men . mD_	26021		9-7-2006-
		30. Name and address of person who com Laeeq Ahmad, MD 73	npleted cause of death (Item 23a) (Type 335–B_Hanover Park		rvland 207	70
Regi	State strar	31. Date liled (Month, Day, Year) SEP 1 9 200	32 Redistrar's Signature		y 1 and 207	, v
3.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death C Month County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ta 10 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Min. 860 Months Days Hours 1 XM 2 □ F une Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? aven LIC 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1☐ Yes 2X No Specify: If Yes, Give Year or Dates: Bi-Racia 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manag O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, me Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Zip Code) 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Tremato 21. Signature of Funeral Service/Licensee 22. Name and Add gral Home, P.A Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failiffer. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPHACEAL months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28e-f ehow

, or items 23a or

natural',

Director

Funeral

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Completed

other treumatic event, the Madical Exernitrer round be nutified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: It liem 27 is marked other than eny injury or other treumatic avant

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

attending physician and for use as the burial-transit ed by the a

this certificate has

the

filled in by

Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica

Examiner Physician/Medical ğ Completed 25. Was case referred to medical P 27. Manner of Death Certification: 1 Natural 3 ☐ Suicide

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

	140	
24a.	Was	
	auto	psy
	perf	ormed?
1 🗆 '	Yes	2 No

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No

1016	5 2/3.	140	
Check on	fy one		
_			

6 ☐Other (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

2	ER/Outpatient	3 🗆 🛭	AOC	Other:	4 🗌 Nursin	g Home	5 Residence	6 Other
a <i>r)</i>	28b. Time of Injury		28c.	Injury at Work?			Describe how inj	
		M		1 TYes	2 🗆 No	1		

28a. Date of Injury (Month, Day Yea 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year) september 18, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. HANOUSE St. Bettimore BL40, ND VAN

1 Inpatient

31. Date filed (Month, Day, Year)

examiner?

1 🗌 Yes

2 Accident

4 Homicide

(Check only one)

29a. Certifier

2 No

5 Pending investigation

6 Could not be determined

32. Redistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:50 AM Velyn SEPTEMBER 15 2006 /Medical 4c. County of Death 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE HOSPITAL OF BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 7. Age (In yrs. last birthday) 9/ Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 218-44-7428 1 □ M 2 1 F Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits nem 4/1 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County Yes 2 No Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 72 21216 OOK Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: 3/ac Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ber Seatric 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Newinaton if item 27 is Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Depertment of Importent: If any injury or ance. Arbutus Mem. PK. 2006 4 □ Donation 5 □ Other (Specify) 2. Name and Address of Facility

Joseph L. Kuss

2722 W. North 21. Signature of Funeral Service Licensee Ave. Baits. Md Home, P 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a CARDIOGENIC SHOCK - day /Medical Due to (or as a consequence of): day Examiner MYDCARDIAL DNPARCTION Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed ATHEROSC LEPOSIS MANY YEARS Due to (or as a consequence of): Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) 4□Pregnant at time of death P.O. I 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Be Completed HYPERCIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 ☐ Yes 2 No Hospital or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Manpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Lescrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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31. Date filed (Month, Day, Year)

32. Reistrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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HOSPITAL OF BALTIMORE

SEPTEMBER 15 2006

nysicia	an	Decedent's Name (First, Middle, L.	_					2. Date of Deatl Month	Day	Year		e of Deat
Medic		Michael 4a. Facility Name (If not institution, g	James		Conno:		ocation of Death	Septembe		2006 ity of Death		:154
xamin	er				Glen ]					· .		
neral		432 Starwood Dri 5. Social Security Number 6.	<u>.ve_#A</u> Sex		If Under 1		If Under 24 Hrs.	8. Date of Birth		Aruno	place (Stat	te or For
ector		5. Social Security Number 6. 104-36-0878	1ॼ M 2□ F 59	Yrs.	Months	Days	Hours Min.	Jan 20,	1947	PA	intry)	
		Usual Residence of Decedent										
1	-	10a. State 10b. County		Town or Loc							10d. Inside	eCityLi ∕es 2.2
offfie	Director		rundel Glen	Burni	1							93 212
2	급	10e. Street and Number	Д.		10f. Zip C				g. Citizen a	f What Cou	intry?	
Total	Funeral	432 Starwood Dri	Ve #A  12. Was Decedent Ever in U.S.	12.14	2106		onio Origina (Co		USA	ace - Ameri	ioan Indian	
Izer	in.	11. Marital Status  1 □ Never Married 2 ☑ Married	Armed Forces?		Yes, specif	y Cuban,	anic Origin? (Sp Mexican, Puerto	Rican, etc.)		lack, White		١,
2	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2	No No	Specify:		Spec	city: Whi	ite	
in in	Completed	15. Decedent's	Education	16a. Deced	lent's Usual	Occupati	on		6b. Kind of	Business/Ir	ndustry	
Med	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life. C	OONOT use	retired)	ring most of work	ing				
2	20 D	12		Dis	patche	er			Trucki	ing		
importent; it ten 2.1 is marked butter than include, you tright so or coast anow injury or other traumatic event, it a Mudical Exercities must be notified at once.	Be (	17. Father's Name (First, Middle, Last				1		e (First, Middle, N		ŕ		
atic	2	Gerald James Con	77					Virginia				
Laur.		19a. Informant's Name/Relationship			-			al Route Number,				
1		Mrs. Helen A. Co						Glen Bu				
or of		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3	000	netery, crem			Sept	. 19,	20c. Location			
lury		4 □ Donation 5 □ Other (Spec	Ches	apeak					Steven			)
D C C		21. Signatur of mere S rvice Lic			. Name and		•		Second			
: • Q		other	M014					Home; Gle		nie,		
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. by one cause on each line.	Do not ente	er the mode	of dying,	such as cardiac	or respiratory arre	st,		Approxir Interval Onset a	Betwee
hysician		Immediate Cause (Final disease or condition	Ling	Can	cer							1000
dical niner		resulting in death)	Due to (or as a conseque	ence of):								
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Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dise to (or as a conseque	enes atjo								
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the burial-transit	Ical E											
s the	음		d.									
of for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnance	cy					234 [	Date of deliv	/en/	
for L	clar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2 ☐ Fetal of 4☐ Pregnant at time of dea	death 3	Ectopic pred				1	Month	Day	Year
ched	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		(420	//						
should be detached	y P	Part II. Other significant conditions	contributing to death but not result	ting in the un	nderlying cau	use given	in Part I.	23e. Did tob	acco use co	ontribute to	the cause	of death
b d b	d by							1 <b>X</b> Ye	s 2□No	3 □ Pro	bably 4	Unkr
shou	Completed							24a. Was ar	241	o. Were aut	onsy findin	nos avai
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rector, pag	ပိ	25. Was case referred to medical					OC Disease A Deser	1	No No	1 🗆 Yes	2□ No	
director, page	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t all DOA	Othor		me 5 Reside		hhar (Cara	4.1	
eral di	늘	27. Manner of D ath		28b. Time of		c. Injury a Work?		28d. Describe ho			iry)	
e funer	150	1) Natural 5 Pending 2 Accident investigat		Injury	м		s 2 No					
by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 289. Place of injury - At non	ne, farm, stre	eet, factory,	office		28f. Location (Str		mber or Ru	ral Route N	vum <i>ber</i> ,
, E	Sert	- Chomicide	building, etc. (Specify)					City or Town	, State)			
completaly filled in by the funeral		29a. Certifier 15. Certifying	Physician: To the best of my know									
oletal	edical	(Check only 2, Medical Ex										se(s)
a ≱ '	×	29b. Signature and title of certifier	o completed cause of death (Item:  32 Registrar's Signaty		29c.	License	number	29	d. Date sign	ned (Month	Day, Yea	r)
2 6		manh	on M.D			D3	9505	2	epten	user	-18,	20
noo C					1 .				,		,	
000		30. Name and address of person wh	o completed cause of death (Item )	23a) (Type, I	Print)	Λ	- 1	^	7	Α.	10	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 29577 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** anessa 074 2006 /Medical Howard County

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Min. | Month, Day, O7-07-4a. Facility Name (If not institution, give street and number) Howard County 4b. City, Town, or Location of Death 4c. County of Death Examiner SA HOSPITA Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 5 214-68-1240 1 ☐ M 2 💢 F Director Usual Residence of Deceden filed within 72 hours after deeth with the Maryland 10a. State ehow. 10c. Town or Location 10d. Inside City Limits Item 27 is marked other then "neturel", or items 23s or 28s-1 ehos other traumatic event, it a Modical Examinar must be notified at Director 1 ☐ Yes 2 No ひい 0 umbia 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Completed by Specify: Slack 3 ☐ Widowed 4 Divorced Year or Dates: 15. Decedent's Education only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne eny injury or other traumatic event (Give kind of rk done life. DO NOT e retire Elementaly/Sucordary (0-12) College (1-4or 5+) DISWIN Informant's Name/Relationship (Type, Brown lothe 20a. Method of Disposition Burial 2 Cremation 4 Donation 5 Other ( 3 Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Ucens llstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or high adjurte. List only one cause on each line. Approximate Interval Between Pulmonary
Due to (or as a consequence of): Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 1 Tyes 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2. No 2**₹** No 1 Yes Division of Vital 1 Yes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ٤ 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3E DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48D Cheryl Leonard 31. Date filed (Mohin, Day, Year) 324 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 Per Phy 8859 9/19/06 JH

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month CAMERON Coy Cameron Sr. 1:55A M SEPT 200 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Genesis Elder Care Caton Manor Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) τ**Σ**Μ 2□ F 73 241-48-6870 04 24 33 NC Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 2925 Clifton Ave 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Roper Eastern 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lucy Wilkerson Arthur Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2925 Clifton Ave, Baltimore, Md Anthony Cameron-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 9/15/06 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

**Physician** /Medical Examiner o the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

5

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercises page.

Baltimore, Maryland 21215-0036

Director

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Completed

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Division of Vital Records, P.O. Box 68760.

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Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):  RET	OTHRIVE			days
Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d	lancy al death 3 □Ect	opic pregnancy ner (s <i>pecify</i> )		23d. Date of d Month	elivery Day Year
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Completed					24a. Whas an autopsy performe	prior to death?	autopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?			26. Place of	Death (Check only one)		
2	1 ☐ Yes 2 ☐ №6	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other:	ng Home 5 Residence	ce 6 □Other (Sp	ecify)
	27. Manner of Death  Natural 5 Pending  Accident investigation		28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fy)	factory, office	28f. Location (Stree City or Town,	et and Number or F State)	Rural Route Number,
Medicai	29a. Certifier (Check only one)  Certifying Ph  Certifying Ph  Certifying Ph  Certifying Ph	ysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occ ation and/or investi	curred at the time, date and p gation, in my opinion, death o	lace, and due to the cau occurred at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
ž	29b. Signature and title of certifier			29c. License number	290	. Date signed (Mor	nth, Day, Year)
	> Soro>	MD		D0053	50 5	EPT 12	2006

NO 9650 Santago Read Suite 110 21045

DHMH 17 Rev 1/2001

3

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supte

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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	Funeral Director			8-7618 ence of Decedent	6. Sex	( ]M 2 <b>⊠</b> F		n yrs. i 83	last birthday Yrs.	) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, 6 / 29			Cour	place (State of htry) YLAND	
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "neture!, or Items 23a or 28a-1 show aimportant: if Item 27 is marked other then "neture!, or Items 23a or 28a-1 show aimportant; or Items 23a or 28a-1 show aimportant; if a Medical Examinar must be notified at anote.	þ	1 🗆 Neve	er Married 2∭X M owed 4 □ Divorc	arried	Amed 1 ☐ Ye If Yes,	Forces?			If Yes, spec	orfy Cuba	Specify:	n, Puerto	Rican, etc.)		Bla Specii	ick, White, <sup>fy:</sup> WHI		
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/Medio Examin		4a. Facility Name (If not institution, give Harbay Huspitel	street and number)			Location of Death	2000000	4c. County of De	ath
Funeral Director		5. Social Security Number 6. Se	x 7. Age (In yrs. la □ M 2√√F	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	(ear)	rthplace (State or Foreign ountry) MD
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Fe, Maryland Z I Z I D-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-f ehow other traumatic event, the Medical Examiner must be notified at	by Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3(X) Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba □ Yes 2112 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.
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06-06880 Anthony Durso Please Type or Print in Black Indelible Ink

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Director			X M 2 F	2 Yrs			Aug. 3	30,2004	Country) MD
any	-	Usual Residence of Decedent  10a. State 10b. County	10c	City, Town or Locat	tion				10d Inside City Limits
*	'n	MD Anne An	undel	Brookly:	n				1 Yes 2 X No
Maryl r 28a-f ed at o	Director	10e. Street and Number			10f. Zip Code		10	)g Citizen of What C	ountry?
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<b>5036</b> Within 72 hours afficie.  The than "natural Medical Examinal"		15. Decedent's Education (Specification Elementary/Secondary (0-12)	college (1-4 or 5+)		nt's Usual Occupa nost of working life			16b. Kind of Busine:	ss/Industry
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Sior Attend r death cctor: by the	ertification:	2 Accident Investi	gation 28e Place of Injury		ווום כו	Yes 2 No	subject	beaten	Rural Route Number City
Divi	ertifi	3 Suicide 6 Could determ	not be	ouse	ot, redicity, emico	building, oto.	or Town, Si Baltimor	tate) 1213 Fas	Rural Route Number, City St. Patapsco Ave.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate that biractors. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a Certifier 1 Certifying Phy	sician: To the best of my knowiner: On the basis of examinational and manner stated				nd due to the caus	e(s) and manner as s	
To To	Me	29b. Signature and title of certifier	and manner stated		29c. Licen	nse number		29d Date signed (	Month, Day Year)
		Yamed buth	MIND		0.0	.M.E.		September 12	, 2006
		30. Name and address of person was Pamela Southall, MD	No completed cause of death Assistant Medical Exa		Penn Street,	Baltimore, M	D 21201		
S	tate	31. Date filed (Month, Day, Year)	32. Resistrar's Sig			-			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** (nmn) DAMIANO 8:00 a /Medical September 18, 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Gardens Nursing Home Lanham Prince George's If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🔀 M 2 🗆 F Months Hours Director 98 020-03-8206 6/10/1908 Italy Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or itema 23a or 28a-f shot other traumatic event, the Madical Examinar must be notified at 1 X Yes 2 ☐ No Directo Maryland | Prince George's Lanham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8200 Good Luck Road by Funeral 20706 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specity: Specify: White 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician 6 Sprague Electric Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be eq pinous ဂ Michael Damiano Filomena Farina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 item 27 Louis M. Damiano - Son 8501 Woodside Court, Lanham, MD 20706 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/19/2006 Alexandria, Virginia 21. Sign and Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 101373 4739 Baltimore Ave., Hyattsville, MD 20781 Muly 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a donsequence of): **Physician** Heart Fadure disease or condition resulting in death) 5 days /Medical Examiner Otheroscleratic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Pulmonar-1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 2□ No 1 Yes 2√ZNo 1 Yes Attending Physician: : After this certification of tuneral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 → No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death.
I Director: Aft
d in by the fur investigation 1 TYes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by filled in by 4 | Homicide Hospital or To criffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei cai (Check only one) o the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Center Dive Greenbelt MD 20770 Stephanie Trifoglio, Mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

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		-	State of Maryland / Department of Health and Mental Hygiene 2006 29583  Certificate of Death Reg. No.
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)  Gordon J Eckenrode  2. Date of Death Month Day Year 6-15 PM
	Examin		Facility Name (If not institution, give street and number)  4c. County of Death  Altimore VA Medical Center Baltings, MD  4c. County of Death
	Funeral Director		Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth  Months Days Hours Min. MAK. 10, 1942  9. Birthplace (State or Foreign Months)  PENNSTLVANIA
	/land		sual Residence of Decedent  a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Ba-f sh	ctor	ARYLAND ANNE ARUNDEL GLEN BURNIE 1□Yes ☼XNº
	3e or 2	al Dire	be. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 UNITED STATES
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturai; or items 23e or 28e-f show say injury or other treumatic svent, I'm Medical Examinat must be notified at once.	by Funeral Director	Marital Status   12. Was Decedent Ever in U.S. Argued Forces? 1962   12. Yes 2 \( No N
21215-0036	within 72 ho ane. than "natur or Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  SARGEANT  U.S. GOVERNMENT
Maryland 2	uld be filed Aental Hygie rked other tic svent, L	To Be Co	7. Father's Name (First, Middle, Last)  BERNIE ECKENRODE  18. Mother's Name (First, Middle, Maiden Sumame)  DOROTHY ELIZABETH GROVE
Mary	12 sho h and h 7 is ma treuma		9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  115 FRANKLIN STREET BALTIMORE, MD 21225
Baltimore,	ages 1 an ont of Heali it: if item 2 y or other		Da. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  METRO CREMATORY  20c. Location · City or Town, State
Baltir	permit. F Departme Importar eny injur		1. Signator of Funeral Service Licensee  KIRKERY RUDDICK IIIVFUNERAL HOME P.A.  421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061
4	Physician		Approximate Inter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Batween Onset and Death issaes or condition  The proximate Interval Batween Onset and Death or condition.
H	/Medical Examiner		Due to (or as a consequence of):
	ate be executed hysician and the burial-transit	Examiner	b. Due to (or as a consequence of): ause. Enter Underfying ause. Enter Underfying ause (Disease or injury ata initiated events southing in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):
68760,	icate be ex physician s the buria	cal	d
.O. Box (	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	FEMALE:  3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Month Day Year 9 Unknown
s, P	es De	by	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
I Record	The law ate has b page 2 s	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	Physicien: Th this certificate ral director, pag	o Be	5. Was case referred to medical examiner?  1
ion of	ter ter	$\vdash$	7. Manner of Death 1. Manuer of Death 1. Matural 5 Pending (Month, Day Year) 2 Accident investigation 2 Pending (Month, Day Year) 3 Pending (Month, Day Year) 4 Pending (Month, Day Year) 4 Pending (Month, Day Year) 5 Pending (Month, Day Year) 6 Pending (Month, Day Year) 7 Manner of Death (Death) 7 Pending (Month, Day Year) 8 Pending (Month, Day Year) 9 Pending (Month, Day Year)
Division	tel or Attendir s after death. el Director: Af ed in by the fu	Certification:	3 Suicide 4 Homicide  6 Could not be determined  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Atternity of the Within 24 hours after de To the Funerel Directo completely filled in by the	edical	9a. Certifier (Check only one)  (Check only one)
)	with Tot	Σ	9b. Signiture and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  P 18814  O9 15 2006
_	4		o. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Albert MD. 22 S. Greene Street Baltimore, MD 21201
	Sta Registi		1. Date filed (Month, Pay, Year)  32 Registrar's Signature

DHMH 17 Rev 1/2001

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			Please  1 - State Registrar	State of M		/ Depa	ırtmer	nt of H		Ment	al Hygi	ene Z	_	29584
	Physici	20	1. Decedent's Name (First, Middle, La	st)							ate of Deatl Ionth	Day	Year	3. Time of Death
	Physici /Medio		Elizabeth		En	sor				-	pt.	14,	2006	9:45 p M
	Examin	ıer	4a. Facility Name (If not institution, give				4b. City		Location of De	ath			ounty of Death	
			Long View Nurs 5. Social Security Number 6.5		je (In yrs. las	t hirthday)	If Unde	Mano r 1 Year	chester	rs. la n	ate of Birth	<u>C</u>	arroll	place (State or Foreign
ŀ	Funeral Director			_M 2⊠F	82	-	Months		Hours Mi		Aonth, Day,		23 En	place (State or Foreign ntry) gland
	land ow		10a. State 10b. County		10c. City, 7	Town or Lo	cation				· <del>-</del> ·			10d. fnside City Limits
	Mary eh	to	MD Carro	l1		На	mpst	ead						1 ☐ Yes 2 🖾 No
	r 288	Director	10e. Street and Number				10f. Zi	p Code			10	0g. Citize	n of What Cou	ntry?
	th wit		4418 Blac	ck Rock Ro	ad				21074				U.S.A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Dece Yes, spe	edent of H	ispanic Origin? in, Mexican, Pu	(Specify 'erto Ricar	res or No- n, etc.)	14.	Race - Ameri Black, White,	
g	or It	by Fu	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give	No				Specify:			S	pecify:	White
Ş	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow the Madical Exercites mast be notified at	pa pa	15. Decedent's E	Year or Dates:		16a. Deced	lent's Usi	ial Occup	ation			16b Kind	of Business/Ir	
Ċ	in 72	plet	(Specify only highest gr	ade completed)		(Give	kind of w	ork done d use retired	during most of w	working				,
212	r the	Completed	Elementary/Secondary (0-12) Unknown	College (1-4or	3+)		Н	ouse	wife			Own	Home	
Maryland 21215-0036	e filed al Hygid other vent, il	BeC	17. Father's Name (First, Middle, Last	)	· ·				18. Mother's N	lame (Fire	st, Middle, M	laiden Su	ımame)	
<u>a</u>	Ments Ments arked	일	John	Heath	er					Jaı	ne I	leath	ner	
al.	and and is my		19a. fnformant's Name/Relationship						and Number or					p Code)
	and feelth m 27 her tr		Heather P. Wolfe	Daughter					ok Road	Har Date	-		D 210 tion - City or T	
ō	if of F		20a. Method of Disposition 1 ☑ Buriaf 2 ☐ Cremation 3 ☐			ce of Dispo n <i>etery</i> , cren								
altimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importent: if item 27 is marked other then "naturel; or items 23s or 28s-f show any injury or other treumatic event, the Macical Examination at 2016 and 2016.		4 Donation 5 Other (Speci		Ever				rdens 9					Maryland
Ba	Depa Impo eny it		21. Signature of Funeraf Service Lice	M. (10	. Kin				ss of Facility				stown l	Road 21136
			23a. Part1. Enter the disease, or con	polications that cause	d the death.				ral Hom				, FID .	Approximate Interval Between
1	Physician /Medical Examiner e priightensit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	S a consequent	nce of):	)	) em	untia	?				Onset and Death
P.O. Box 68760,	Hospital or Attending Physicien: The law requires thet the death certificate be 4 hours effer death.  Funerel Director: After this certificate hes been signed by the attending physicic funeral Director: After this certificate hes been signed by the attending physicic lifed in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	1 Live birth	4 Pregnant at time of death 5 □				□Ectopic pregnancy □ Other (specify)				d. Date of deliv	very Day Year
	uires thet signed b Id be deta	by	Part II. Other significant conditions	contributing to death I	out not resulti	ing in the u	nderlying	cause giv	en in Part I.					the cause of death?
ecor	law requir	Completed									24a. Was a autops	y	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
<u> </u>	: The										perform	No No	1 Yes	2 No
<u> </u>	hysicien: The law his certificate hes t I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospitaf:				Oth	26. Place of □					
ō	Phys r this ral dii	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati	ent 2 Ef	R/Outpatien 8b. Time of		OA	400 Nursing		5 ∐ Reside Describe ho		Other (Spec	ify)
o	ding th. Afte	tlor	1 Naturaf 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury	м	28c. fnjur Wor 1 🗌	k? Yes 2∐No					
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not 1 4 Homicide determined	28e. Place of fr	jury - At hom tc. (Specify)	ne, farm, str	eet, facto	ry, office		28f. l	ocation (St City or Town	reet and i	Number or Rui	ral Route Number,
	Hospit     24 hours     Funere letely fille	edical (	29a. Certifier Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manners	of examinatio	ledge, death on and/or in	occurre vestigation	d at the tir	ne, date and pla pinion, death o	ace, and o	lue to the ca	ause(s) ar ate and p	nd manner as lace, and due	stated. to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	In a m	0		2		e number	5	5		signed (Month	
}	Ĭ		> @yamz	DXC III	<i>リ</i>			T) (	5170			C	4-15-	-06
	H		30. Name and address of person who	completed cause of	death (ftem 2	23a) (Type,	Print)	Pib	رو	HOLT	nost	~e^	a m	D 21094
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	re food	25			•				

DHMH 17 Rev 1/2001

		•	1 - State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H rtificate of I	lealth and N Death	fental Hyg	iene g, No. 200	6 29585
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
	hysici: Medic/		Charlie P. Eckard					Month 09	Day Yea 200	
	Examin		4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
	uneral rector		Franklin Square  5. Social Security Number  6. Sex  231-56-4281	7. Age (In yrs	Center :. last birthday) Yrs.	ROSEC If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) (	irthplace (State or Foreign Country)
	rector		Usual Residence of Decedent	61			<u> </u>	Nov. 28	1944 V	'irginia
ylanc	MOI W		10a. State 10b. County	10c. C	ity, Town or Lo	cation	-			10d. Inside City Limits
Ma	Her	Director	Maryland Baltimon	re D	undalk					1 ☐ Yes 2 X No
th the	or 28	lre	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What (	Country?
E W	23a		8148 Bullneck Road	ā		2122	2		United St	ates
r dea	e in	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		nerican Indian,
hours after death with the Maryland	al', or iteme 23a or 28a-f ehow Examinar must be motified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
hour	al Ex	d b	3 Widowed 4 Divorced	Year or Dates:	16a Dagg	dent's Usual Occup	otion			hite
n 72	plan	Completed	15. Decedent's Education (Specify only highest grade	completed)	(Give	kind of work done of NOT use retired	during most of work	ing	16b. Kind of Busines	sindustry
within iene.	r than the Mu	E	Elementary/Secondary (0-12) 8 years	College (1-4or 5+)	Assem	iblv - Gen	neral Mot	ore	Manufact	uring
Hygi	d other	60	17. Father's Name (First, Middle, Last)	-	110001	<u></u>	18. Mother's Nam			dring
uld be Mental	le marked other than aumatic event, train	To B	Earnest Eckard, Si	<b>:</b> • • • • • • • • • • • • • • • • • • •			Abbi	e Cather	ine Smith	
2 should and Men	- H		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street			City or Town, State	, Zip Code)
and	n 27   er tra		Diann M. Eckard	(Wife)			Road D	undalk,	Maryland	21222
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	r oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Re		Place of Dispo cemetery, crer	sition (Name of natory or other place		Date	20c. Location - City of	or Town, State
Pages ment of	ant:		4 Donation 5 Other (Specify)		eadwate	rs	9/20	/2006	Headwater	s. Va.
permit. Depentr	Important: if Item 27 le marked eny injury or other traumatic ex once.		21. Signature of Funeral Service Licenses	,	D	. Name and Addres uda–Ruck	Funeral	Home of	Dundalk,	Inc.
			23a. Part1. Enter the disease, or complic	ations that caused the des		922 Wise	Avenue	Dundalk,	Maryland	21222 Approximate
20			shock, or heart failure. List only one	cause on each line.				or respiratory arre	, , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
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		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a onse	quence (f):	oma				
D 3	ansit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events							
9×90	sicien and burial-transit	Examiner	resulting in death) Last	Due to (or as a conse	quence of):					
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	ing pl	Med	IF FEMALE:	7937						
ag.	ettending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregrammed in the common of the common</li></ul>	tel death 3 □	Ectopic pregnancy			23d. Date of d	elivery Day Year
The law requires that the death certifi	by the e	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	Other (specify)				
thatt	200		Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
S S	5.5	d by	_			, ,		1 □ Ye	s 2 12 No 3 🗆	Probably 4 Unknown
§ §	should should	Completed						24a. Was ar	24b Were	autopsy findings available
9 e	ate has page 2	dwo						autops	y prior to ned? death?	completion of cause of
	ξ, e	0	25. Was case referred to medical				26. Place of Deat	1 Yes 2		es 211/No
Physician:	S F	0 8	examiner?	spital: 1 unpatient 2[	☐ ER/Outpatier	nt 3 DOA Oth		A STATE OF THE PARTY OF THE PAR	nce 6 □Other (Sp	pecify)
- g		T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				w injury occurred	
at di	he fu	atlc	1 Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2 □ No			
or Att	irecto n by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or i , State)	Rural Route Number,
pitel o	illed i		29a Certifier 1/D Certifying Physi	eine. T. H. I. at at at a la						
To the Hospitel or Attending Pl within 24 hours after death.	e Fun	edical	(Check only 2 Medical Examinations)	clan: To the best of my kr er: On the basis of examir and manner stated.	nation and/or in	vestigation, in my o	pinion, death occur	ed at the time, da	its and place, and d	as statou. ue to the cause(s)
To th withir	Сотр	×	29b. Signature and title of certifier			29c. Licenso		_	d. Date signed (Mo	nth, Day, Year)
			· M			Do	0064755		9/16/06	
	0		30. Name and address of person who con	pleted cause of death (Ite	em 23a) (Type,	Print)			1110 - 7.W	
	`		Dr. Minus Vasilia 31. Date filed (Month, Day, Year)	des MD, 90	00 Fran	Klin Squa	are Drive	, Baltim	ore MD :	21237
2.	Sta Registr	-	cen 1 0	des MD, 90  32. Registér's Sign  2006	Talule /	boarde	•			
			3557							

		ľ	For State Registrar	State of I	Marylan		artment of rtificate o				giene	2006	29586	5
	Physici	an	1. Decedent's Name (First, Middle BOB	e, Last)	Est	-60				2. Date of De. Month	Day	Year	3. Time of Death	_
	/Medio		4a_Facility Name (If not institution	, give street and numb		<u>~</u> 5	4b. City, Town	, or Location	of Death	SEPTE		County of Dea		
	Examili	ei		XVIEW CIRC			0	TORE				N/A		
	Funeral		5. Social Security Number		Age (In yrs. I		If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birt (Month, Da	th y, Year)	9. Bir	thplace (State or Foreign	n
	Director		526-24-3145 Usual Residence of Decedent	1 <del>∏</del> M 2□F	_83	Yrs.						1922 Ar		
	/land		10a. State 10b. County		10c. City	, Town or Lo	ocation		-				10d. Inside City Limits	;
	a-f sh	tor	Maryland Balt	timore	D	undal	k						1 ☐ Yes 2 ☐XNo	)
	or 28	Director	10e. Street and Number				10f. Zip Code	)			10g. Cit	izen of What C	ountry?	
	ath w		3412 Sollers Po				212					ted Sta		
	frems	Funeral	11. Marital Status	12. Was Decede	s?	S. 13.	Was Decedent o If Yes, specify Cu	f Hispanic Ori Jban, Mexicar	igin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		
936	urs afi	þ	1 ☐ Never Married 2 🙀 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 1 Yes 2 If Yes, Give Year or Date	s: WW	II	1 ☐ Yes 2 🛣 N	lo Specify:				Specify: W.	hite	
21215-0036	s within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-1 show the Mazical Examinat must be natified at	Completed	15. Deceden (Specify only highes	t's Education		16a. Dece	dent's Usual Occ	upation	et of worki	na	16b. Ki	ind of Business	/Industry	
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and	e d fa	To Be	Victor Estes	Lasiy						a Amos	Maidell	Sumame)		
Maryland	2 should be and Mental Is marked o aumatic eve	F	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stre				er, City o	r Town, State,	Zip Code)	
	s 1 and 2 should f Health and Men item 27 Is merke other traumatic		Anna Estes (Wi:	fe)				s Poin	nt Ro	ad Dun	ndal)	k, Mary	land 21222	
Baltimore,	jes 1 and 2 of Health If item 27 I		20a. Method of Disposition 1 □ Burial 2 X Cremation			lace of Dispo emetery, crea	osition (Name of matory or other p	lace)	D	ate	20c. Lc	ocation - City or	Town, State	
ţ	Pag tment tant: jury c		□ Donation 5 □ Other (S	pecify)	Hi1		Service			/2006	TOT	wson, M	aryland	
Bai	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Synal of Funeral Service	Licensige	1 a	) 1	2. Name and Add Duda-Ruc	k Fune	ral	Home of	Dui	ndalk,	Inc.	
	4	Contract of the Contract of th	23a: Part1. Enter the disease, or	complications that cau	sed the death		7922 Wis					aryland	Approximate	
	Pnysician		shock, or heart failure. List Immediate Cause (Final	only one cause on each	h line.			, ,		. ,			Onset and Death	
	/Medical		disease or condition resulting in death)	- u	as a consequ	uence of):							BAYS	_
	Examiner		Sequentially list conditions	b. RENA	1L F	Aller	RE						DAYS	
0	ad sit	Iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or	as a consequ	ience of):								
7.	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of);								
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9	tificate ig physi as the b	fedical		J										
Вох	eath certific attending pl for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnal		⊒Ectopic pregnar	nev				23d. Date of de	•	
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cor	w raqu s been shoul	lete	Hypertensi	on Digt	etes	Mo	litus,	1		24a. Was	an	24b. Were a	topsy findings available	
Re	The lav ate has page 2 s	Completed	Passing topy	C'I	7		, , , , ,			autop perfo		prior to death? 1 ☐ Yes	completion of cause of	
ita		BeC	25. Was case referred edical	ac luve				26. Place	of Death	(Check only o		10.16	2010	
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o u		lon:	27. Manner of Death  1 XNatural 5 ☐ Pendin	9	njury Day Year)	28b. Time o Injury	W	lork?		28d. Describe h	now injur	y occurred		
Division of	tend death tor: the	Certification:	2 Accident investig	not be	Injuny - At ho	ma farm et	M 1; reet, factory, offic	□Yes 2□	_	28f Location /S	Stroot an	d Number or Pi	ural Route Number,	
Di∨	i ji te	ertif	4 ☐ Homicide determ	building	etc. (Specify	) , raini, su	eet, lactory, onic	Ð	2	City or Tow	vn, State	)	arar Houte Mamber,	
-	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by		29a. Certifier 1 Certifyin	g Physician: To the be	st of my know	wledge, deat	h occurred at the	time, date an	id place, a	and due to the	cause(s)	and manner as	stated.	:10
	the Ho in 24 the Fu oplete	ledical	one)	Examiner: On the basi and manner										
	To the within 2 To the comple	Σ	29b. Signature and title of certifie	75			29c. Lice	nse number	0-		29d. Dat	e signed (Mont	h, Day, Year)	
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	04		William Greenot	who completed cause of	5505	Hopk	ins Baxv	iew Ci	rele	Balti.	nove	Mary	h, Day, Year)  DE  And 21224	
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	Registr		SEP 19	2006	yes h	r fig	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 8.20 PM SEPT 2006 16 Margaret Eggleton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL HGNES 5T. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1□M 2MF Yrs. 212-28-8015 Usual Residence of Decedent 11/07/1930 Director Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28e-f ehow The Medical Exactings must be notified at 1 Yes 2 No Directo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5903 Robindale Road 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 □ Divorced White 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other It any injury or other traumatic event, Ita once. Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Mary Connor Daniel Edward Shay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geoffrey Eggleton - Son 201 S. Hilltop Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 9/21/2006 Baltimore, Maryland 21. Signature of Funeral Service Licegsee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. athleen 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC 2 days. **Physician** /Medical Due to (or as a consequence of): 2 months. Examiner COLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 4 Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate 2 No 1 ☐ Yes 1 Yes or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 npatient 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28d. Describe how infury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours a Decrtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of confider P19906 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE BALTIMORE RIYANK 900 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Blace ORIGINAL

			1- State of Maryland / Department of Healt Certificate of Dea		lental Hygier Reg. h	711116	29588
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Aunah Eaddy		2. Date of Death Month D Schein ber	Day Tt 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locat  UNIVUSITY & Maryland Medical Center  Bulkmer			4c. County of Death	
	Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 1 Yea	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Yea 03 04	9. Birth	place (State or Foreign ntry)
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	deeth with the Maryland ma 23a or 28a-f show r must be notified at	ctor	MD NA Baltimore				1 XYes 2 □ No
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9	s after d	y Funerai	Armed Forces? If Yes, specify Cuban, Men  1 ☐ Yes 2 🛣 No  If Yes, Specify Cuban, Men  1 ☐ Yes 2 🛣 No  1 ☐ Yes 2 🛣 No  Specify Cuban, Men  1 ☐ Yes 2 🛣 No  Specify Cuban, Men  1 ☐ Yes 2 🛣 No  Specify Cuban, Men	oxican, Puerto ecity:	Rican, etc.)	Black, White	
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<u> </u>	shoul and Me mark umati	Ĕ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nu			y or Town, State, Zij	Code)
Ě	and 2 Balth a n 27 ie		Betty Dixon-Sister 5120 Chalgrove	Ave,	Baltimo	re, Md	21215
ע	Pages 1 nent of He int; if iten		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	1		Location - City or T	
	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 le marke any injury or other traumatic QDCB.		4 Donation 5 Other (Specify) King Memorial Par		3/06 Ra	ndallst	own, Md
Ö	permit. Departminemporte any inju		21. Signature of Funeral Service Licensee  March F/H W  4300 Wabash		Baltimo	re. Md	21215
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one couse on each line.  Imm. faite Cause (Final disease or condition resulting in death)  a	ch as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours sifet death sets that this certificate has been signed by the ettending physician and the Funeral Director: After this certificate has been signed by the ettending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, 1 any, leading to instructiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.				
9	rtificati ng phy as the	Medic	IE ECNAL C.	5 55			
.O. DO.	thet the death certific ed by the ettending p detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
- (23)	w requires thet the base of the control of the control of the detaction of the control of the co	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.		o use contribute to t 2MNo 3 ☐ Prol	
יייי	sician: The law r certificete hes be irector, page 2 sh	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of 2 No
ב ב	ician: certific ector.	Be	examiner?	Place of Death	Check only one		
5	ing Phys iner this ineral dir	on: To	1 D Yes 2 No  Hospital: 1 Inpatient 2 Z ER/Outpatient 3 DOA  Other: 4 □  27. Manner of Death 1 Natural 5 Pending  (Month, Day Year)  1 Natural 5 Pending		ne 5 Residence 28d. Describe how in		(v)
DIVIDIO	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funerel Director: Atter this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined investigation 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street a City or Town, Sta		al Route Number,
	Hospitu     24 hours     Funere letely fille	Medical C	29a. Certifier (Check only one) The Control of the best of my knowledge, death occurred at the time, date of the control of the best of my knowledge, death occurred at the time, date of the control of	te and place, a , death occurre	and due to the cause( ed at the time, date a	(s) and manner as s nd place, and due t	tated. o the cause(s)
	To the within To the	Me	29b. Signature and title of certifier attending Daysteran 29c. License number	ber		Date signed (Month,	
	(1)	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	240	Syoy	truber 7	1.2006
1	+		Marcia Cort. mo 22 South Gruno	Street	Balto	Ember 7 Md 211	201
	Sta Registr		31. Date filed (Month, Day, Year)  SFP 1 9 2006  32. Segistrar's Signature				
	. Ingligit	-11	SEP I D ZUUD   MINING IN 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fit 859 9-19-06 vt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ψ /Medical 2006 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner 3AL If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, MEMORIA HOSPITAL If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 A F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Directo MARYLAND 10e. Street and Number 10f. Zip Code F 10g. Citizen of What Country? ö ALTO. ST. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify. Specify þ 3 Widowed 4 Divorced ACK "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11THGRADE of Health and Mental Hygic Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ANDREU 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARONE BALTIMORE ST., BALTO. HD. 21223 OLKES (DAUGHTER) 1010 W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Deportment of Himportant: If Its any njury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 23-06 4 ☐ Donation 5 ☐ Other (Specify) KING MEM, PARK WOODLAWN, MARYLAND 21. Signature of Funeral Service Livense THE BROWN JR, FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory affest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia monte /Medical Due to (or as a consequence of): Examiner 2011/ Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit abete Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu investigation 1 Tes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memonial Hospital, 201 E. University Pkwy, Baltimar, MD 21218

Registrar DHMH 17 Rev 1/2001

State

Asha Manchar, MD
31. Date liled (Month) Pays Year

SFP 19

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

ay 11. 1 aooi		1- For State Certificate of Death Registrar	Re	g No 200	6 2959
Physicia Medical Examir	17/	1. Decedent's Name (First, Middle,Last)  Jay W. Faust	Date of Deat     Month     Septembe		3. Time of Death 1605 hrs
Alcaicaí Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De		4c. County of Death	
		Upper Chesapeake Medical Center Bel Air		Harford	
Funeral Director		219-38-4910 1X M 2 F 35 Yrs.	4Hrs. 8. Date of Birt Min. 09/17/	Foreini	nplace (State or Intry)Maryland
šue	}	Usual Residence of Decedent  10a State			10d. Inside City Limits
and f show	5	Maryland Baltimore Kingsville			1 Yes 2 X No
th the Maryland 23a or 28a-f show any notified at once.	Dire	10e Street and Number 10f. Zip Code 21087	10	Og. Citizen of What Coun	try?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or items 23a or 28a-f she arife event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married   3 Widowed 4 Divorced If Yes, Give Year   12 Was Decedent Ever in U.S   Armed Forces?   13 Was Decedent of Hispanic Origin?   If Yes, specify Cuban, Mexican, Pu		14. Race - Americ White, etc.	
urs after	핡	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind		16b. Kind of Business/Ir	
6 172 ho an "na ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 College (1-4 or 5+)  Fire fighter		Baltimore (	
5-0036 led within 7. lygiene other than	E I		lame (First, Middle, N	Fire Depart	ment
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	Bec	John Faust Anna	Ricciar		
O 21 should nd Mer is man	၉	19a Informant's Name/Relationship (Type, Print )  19b Mailing Address (Street and Number 19b Mai			Zıp Code)
Md 2 md 27 mm 27 mm 27	1	Mrs. Joyce M. Faust (wife) 3804 Miller Road, K  20a. Method of Disposition 20b Place of Disposition (Name of cemetery.	Date	20c. Location - City or	Fown, State
Baltimore, Department of Hee Important: If ite		1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Parkwood Cemetery 9	/16/2006	Baltimore,	Maruland
Baltimo permit Page Department ( Important: injury or oth	Ī	21 Signature 1 Grinaral Service ansee 22 Name and Address of Facility Sci	chimunek F	uneral Home	s
	- 1	9705 Belair Rd.,	, Baltimor	re, MD 2123	Approximate Interval
Physician /Medical	100	failure. List only one cause on each line  Immediate Cause (Final disease a. Multiple Injuries	ac or respiratory arre	ost, shook, of fleat	Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):			
-	-	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
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uted nd ransit		events resulting in death) Last  Due to (or as a consequence ot).  d			
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED			
be by he		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pre	egnancy	23d Date of delivery  Month D	ay Year
Box 68. death certifi	sician	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	-9,		, , , , ,
he d he d	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did to	bacco use contribute to t	he cause of death?
, P.O. res that th	Š		1 Yes	2 No 3 Prob	ably 4 Unknown
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Recc The lay	Completed		perfor	med? death?	
Vital Rec ssician: The l his certificate l director, page	Be	25 Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other No.			
Division of Vital Records, P.O tal or attending Physician: The law requires that treater death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaed	욘	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?		Residence 6 Other:	
on c ending ath or: Af	Certification:	1 Natural 5 Pending Sep 11, 2006 1531 hrs 1 Yes 2 ✔ No	Driver motor	cycle auto collision	1
Division pital or Attent ours after death erral Director: filled in by the	iţica	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc	28f Location (S or Town, S	Street and Number or Run	al Route Number, City
Dispital hours ; filled	9	4 Homicide determined (Specify) Local Street	Route 7 & R	oute 152, Joppa, N	
To the Hospital within 24 hours. To the Funeral completely filled	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, death occurred at the time, date and place, one)			
S on Sign	Me	29b. Signature and title of certifier 29c License number		29d Date signed (Mon	th, Day, Year)
		Pamek Fourthers (MD)		September 12, 20	006
15		30. Name and actress of person who completed cause of death (Item 23a)  Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201		
	ate	Leo et la	VID 2 1201		
Regist		1. AA			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

The state of Maryland 7 Department of Health and Mental Hygiene

For State Registrar 2959 I Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 6, 2006 **Physician** 11:10 AMM Arthur Fazzuoli /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sparrows Point 8 Short Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min XXM 2□F Yrs. Aug. 12,1920 Director Maryland 213-07-2153 86 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location ●how or then "naturel", or iteme 23a or 28a-f ehov the Wedical Examinar must be notified at Sparrows Point 1 ☐ Yes 2XXNo Baltimore Maryland Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21219 8 Short Lane United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status illed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other then 9 Years Steelworker Steel Industry other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gabriello Fazzuoli Dora Ravoria ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie M. Whetzel (Friend) 8 Short Lane Sparrows Pt. Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Depertment of H Important: If its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/15/2006 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. one Dundalk, Maryland Approximate Interval Between Onset and Death and 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) o cardial in **Physician** /Medical Due to (or as a op sequence of) Examiner Therosclerotic CardioVoscular Dise Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death signed by the a 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only opts) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 60A Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 Tes 2 No investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 21237 Baltimore, MD #102, 6830 Hospital Drive Martin J. Sheridan, M.D 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State 2006 SEP 19 Registrar

		State Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of I	Death	2. Date of Deat		3. Time of Death
ysicia Aedic		Sandra Jean Fisher					Month 09	16 200	01:35
nedic amin		4a. Facility Name (If not institution, give s	treet and number)			r Location of Death		4c. County of D	
		Stella Maris	7. 4	forma to hade story to	Timonium If Under 1 Year	If Under 24 Hrs.	9 Data of Birth	Baltimor	
eral ctor		5. Social Security Number  214-76-5759  Usual Residence of Decedent	7. Age (in yrs. 3 M 2 X F 45	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/10/19	960 Ma	Birthplace (State or Fore Country) ryland
=		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Lim
tified	ctor	MD n/a	Balt	imore					1 ⊠ Yes 2 □
20	Funeral Director	10e. Street and Number			10f. Zip Code 21214			0g. Citizen of What U.S.A.	Country?
must	erai	2706 Hamilton Aven	12. Was Decedent Ever in U	.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto			mencan Indian,
event, the Medical Examiner must be notified at	by Fun	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	If Yes, specify Cuba 1 ☐ Yes 2 🛱 No		Rican, etc.)	Black, W Specify:	
Sal Ex	ed b	15. Decedent's Edu		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	White ess/Industry
Medis	piet	(Specify only highest grade		(Give	kind of work done DO NOT use retired	during most of worki d)	ng		
4	Completed	12		Home	emaker			Own Home	
event, II	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
	2	John M. Fisher  19a, Informant's Name/Relationship (Ty)	ine Print)	19h Maili	na Address (Street	Emily E.		City or Town, Stat	e. Zip Code)
other traumatic		John Fisher, Broth	•		Juneberry				e, MD 21061
other		20a. Method of Disposition	205 [	Dines of Dines	naition (Names of	- I		20c. Location - City	
ry or	i	1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State   Hi]	Itop S	matory of other place Service Co	õrp.¦ 09/19	9/2006	Towson, M	Maryland
eny injury or o once.		21. Signature of Funeral Service License	9e		2. Name and Addre	ess of Facility Led	onard J.	Ruck, Ir	nc.
: g		23a. Part J. Enter the disease, or compli	Botes			ord Rd., I			Approximate
cian lical iner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events	Due to (or as a consequence).  Due to (or as a consequence)	quence of):					Onset and Death
as the burial-transit	cai	resulting in death) Last	Due to (or as a consect d					23d. Date of	delivery
80	B	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	el death 3	□Ectopic pregnancy □ Other (specify) _	у		Month	Day Year
ched for use as the	ıysıcı	1 ☐ Yes 2 🛣 No 9 ☐ Unknown							
be detached	d by Physician/Med	1 ☐ Yes 2 🗶 No	ntributing to death but not res	sulting in the t	underlying cause giv	ven in Part I.			
page 2 should be detached	Completed by Physici	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	ntributing to death but not res	sulting in the u	underlying cause giv	ven in Part I.	1 ☐ Ye	n 24b. Were prior	Probably 4 XUnkn a autopsy findings avail to completion of cause
rector, page 2 should be detached	Be Completed	1 ☐ Yes 2 Mo 9 ☐ Unknown  Part II. Other significant conditions c	Uppoint to			26. Place of Deat	1 Yes 24a. Was a autops perform 1 Yes 2	n 24b. Werr prior death	Probably 4 NUnkn a autopsy findings avail to completion of cause how yes 2 No
al director, page 2 should be detached	To Be Completed	1 ☐ Yes 2 Mo 9 ☐ Unknown  Part II. Other significant conditions c	Uppoint to		ont 3□ DOA Othor	26. Place of Deather: 4 □ Nursing Hory at	24a. Was a autops perform 1 Yes 2	n 24b. Werr prior death	Yes 2□ No
funeral director, page 2 should be detached	To Be Completed	1 ☐ Yes 2 Mo 9 ☐ Unknown  Part II. Other significant conditions c	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie 28b. Time of Injury	ont 3 DOA Other	26. Place of Deather: 4 □ Nursing Hork?  Yes 2 □ No	24a. Was a autops perform 1 Yes 2 autops perform 1 Yes 2 autops 2	n 24b. Were prior deat 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 Nunkning availate completion of cause here 2 No
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funeral director, page 2 should be detached	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Getermined	Hospital: 1 Inpatient 2 Inpati	ER/Outpatie 28b. Time of Injury nome, farm, st	ont 3 DOA Office th occurred at the tr	26. Place of Deather: 4 \( \text{Nursing Ho} \) Yes 2 \( \text{No} \) No me, date and place, opinion, death occurred.	24a. Was a autops perform 1 Yes 2 autops 2 autop	n 24b. Werr prior death ned? 2 No 3 Commod? 2 No 10 Commod? 10 Commod? 2 No 10 Commod ned to the stand Number on 2 State) 2 No 2 N	Probably 4 Nunkning availate to completion of cause to completion of cause Yes 2 No  Specify) HOSPI  If Rural Route Number,  If as stated, due to the cause(s)
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DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

		For State Registrar  1. Decedent's Name (First, Middle, Last)		Cei	tificate of l	Jean	2. Date of De	Reg. No.	3. Time of Death
ysicia		EDWARD FRY					Month	Day Yea	r
Medic		4a. Facility Name (If not institution, give s	treet and number)		4h City Town or	Location of Death		4c. County of De	-
kamin	er	BALTIMORE - WASHIN		CITIVE	CLEN BI			44 WHA	
		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		Sirthplace (State or Foreign
neral ector		194-36-5929 ¹\\\\	M 005	1 Yrs.	Months Days	Hours Min.	8. Date of Birl Month, Da 7-23-15	945 1	Country) A
	-	Usual Residence of Decedent  10a, State 10b, County	10c	City, Town or Lo	ecation		<u> </u>		10d. fnside City Limits
en injury or other traumatic event, the Medical Exarciner must be notified at once.	٥	MD Anne Aru			n Burnie				1 ☐ Yes 🔏 ☐ No
	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
		601 Washington Ave	•		21060			USA	
- The same of the	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No ff Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	- 14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. white
	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation	kina	16b. Kind of Busines	ss/Industry
	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired Lirways	d)	mg	Operati	ons
	S	12				19 Mothods Nam	o /First Middle	Maiden Sumame)	
	Be	17. Father's Name (First, Middle, Last)  Aaron P. Fry					es McAnd		
	ပို	19a. Informant's Name/Relationship (Type	na Print)	10h Maili	na Address (Street			er, City or Town, State	Zin Code)
		Mrs. Elizabeth Fry						ie MD 2106	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R  + ☐ Donation 5 ☐ Other (Specify)	20 emoval from State		osition (Name of matory or other place cremat:		Date 3/2006	20c. Location - City Stevensvi	
once.		21. Signature Funera Service Liber se	MO1	364	Second A	ss of Facility Sirve SW Gle	ngleton en Burni	Funeral Ho e MD 21061	ome P.A
		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the d	leath. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
n		Immediate Cause (Final disease or condition	SUDDEN	ARBIAC	NEKTU				Onset and Death
al er		resulting in death)	Due to (or as a con		V 5451 15				
	_	Sequentially list conditions,	VELITAI		FIBRICAT	yor			2400 K
	lne	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con		Luca. bi	SENSE			10 YEARS
	I Examiner	that initiated events resulting in death) Last	Due to (or as a con		TERY DI	761876			10 16447
	edical		l						
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 I I 4 Pregnant at time 9 Unknown	Fetaf death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Dale of Month	delivery Day Year
	ρ	Part II. Other significant conditions cor	ntributing to death but not	resufting in the u	underlying cause giv	en in Part I.			e to the cause of death?  Probably 4 □Unknown
	etec	THERLENCION					24a. Was	an 24h Were	autopsy findings available
	Completed						auto perfe	psy prior death	to completion of cause of
	ပိ	25. Was case referred to medical				00 Di ( D	1 Yes		'es 2⊠ No
	00	examiner?	lospital:	2 ER/Outpatie	nt 3□ DOA Cth	26. Place of Dea		dence 6 Other (S	inacita)
	lon; To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. fnjui	4 🗆 I (UISING)	1	how injury occurred	рвспу)
	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - building, etc. (Sp	At home, farm, st			28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
	edical C	233. Centiled 1. Centifying Physical Examinate)	sician: To the best of my ner: On the basis of exar and manner stated.	hnowledge, deal mination and/or in	threecurred at the ti nvestigation, in my o	na, date and clare opinion, death occu	i, and dua to the irred at the time,	name(s) and manner date and place, and o	as stated due to the cause(s)
	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mi	onth, Day, Year)
1		vale Constabilità	My Coor		De	11750		9-16-2	.006
		30. Name and address of person who co							

State of Maryland / Department of Health and Mental Hygiene 2006 29594 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stephanie Leigh Gorman-Lyons September 16, 2006 3:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3206 Beverly Road Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Days Hours Director Yrs. 571-93-4020 33 MAR 6, 1973 California Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Івете 23а 21214 USA 3206\_Bever1v\_Road Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me College (1-4or 5+) 5+ Elementary/Secondary (0-12) Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mentel ! ၉ Henry Gorman Elaine Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 3206 Beverly Road Edward S. Lyons, Jr./Husband Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot ance. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/16/06 Baltimore, MD 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Cremation Society of MD, Edward A Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 s 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death |Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ №6 Certification: To his After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural death. filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours effect To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month/Day, Year) 1 1 30. Name and addres of person who complet tuse of death (Item 23a) (Type, Print) 21230 BROADWAY 31. Date filed (Month, Day, Year) State SEP 1 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene  $200\,$ 

29595 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 15, 2006 **Physician** 12;43A. M MARY ANNA GAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CARROLL CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER ff Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MAY 13, 1913 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 ☐ XF MARYLAND Yrs. 93 Director 219-22-5037 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location worle 10a. State 10b. County r than "naturel", or Items 23a or 28a-f ehov the Medical Examinar must be nutified at 1 ☐ Yes XXNo Director ANNE ARUNDEL GLEN BURNIE MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 UNITED STATES 814 NORTH SHORE DRIVE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 微XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specity: δ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 le marked other than " Elementary/Secondary (0-12) Coflege (1-4or 5+) FOOD SERVICE COOK 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ANNA MURRY PETER JEROME REED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at Important: If Item 27 1e eny injury or other trau 37 W. MAYER DRIVE FINKSBURG, MD 21048 MARY LEE TASKER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State SEPT. Dat 18, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2006 ELKRIDGE, MARYLAND MEADOWRIDGE MEM. PK. 4 Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee KIRKLEY-RUDDICKY FUNERAL HOME P.A. CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Box 68760, eq ian/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 Other (specify) Physic P.0. detached 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy 2 No 1 Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9-15-06 address of person who completed cause of death (Item 23a) (Type, Prin) 31. Date filed (Mohth, Day, Year) Agistrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 200629596 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Year Month Physician 145PM VO end September 152006 ne a /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner DL 1 MOVE anda OWN 8. Date of Birth (Month, Day, Y Feb. 28, f Under 1 Year If Under 24 Hrs. V. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Year Months Days Hours Min 1 □ M 2 🖾 F Yrs. 214-36-9933 66 Maryland **Director** Usual Residence of Decedent deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23e or 28a-f ahow the Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21104 U.S.A. 4414 Wards Chapel Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status o filed within 72 hours after Il Hygiene. other then "naturel", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store permit. Pages 1 and 2 should be flik Department of Heelth and Mental Hy importent; if item 27 is marked other any injury or other traumails access 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Preston Bossom Theresa Bataz 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Gittere Son 4012 Wards Chapel Road, Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-19-06 Evergreen Mem. Park Finksburg, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee 11824 Reisterstown Road, Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Inset and Death Immediate Cause (Final Prysician SDIYa LOV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner na Non Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit a rebr OV Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the etter d be detached for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Year Month Day 4 □ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 1 No 1 TYAS To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Diractor: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No / Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Sate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☑Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No м 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number September 15 2006 Hospitalist 62912 a 30. Name and address of persor cause of death (Item 23a) (Type, Print) Co KO adkandalist and DWN 9 Y d 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 2006 Registrar

			State of Maryland / Department of Health and M  1- State Registrer  Certificate of Death	fental Hygi	_	6 29597
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last)  HENRY MELVIN GOTSHALL, SR.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	2. Date of Death Month September	Day Year	3. Time of Death
	Funeral Director	ner		8. Date of Birth (Month, Day, 11-06-1	Prince 9. Bi	George's httplace (State or Foreign country) ryland
Melvin	DESILITIONE, METYIETTO Z 12.15-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Umportant: If item 27 is merked other than "natural", or itema 23s or 28s-1 show any injury or other traumatic avant, the Medical Examinal must be notified at any since.	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Maryland  Prince George's  College Park  10e. Street and Number  5209 Kenesaw Street  11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  1 Never Married		g. Citizen of What C  U.S.A.  14. Race - Am  Black, Wh	erican Indian,
Henry	IIG KIKID-UUSC be filed within 72 hours a lai Hygiene. d other then "natural", or went, the Medical Exem	Be Completed by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1963  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  1 1	ing	6b. Kind of Busines: United St Postal Se	ates
Jetsha 11,	Daltimore, Maryland bentification. Pages 1 and 2 should be file apparent of Heelth and Menial Hymporant: if item 27 is marked oth my highty or other traumatic event and e.	ToT	19a. Informant's Name/Relationship (Type, Print)  Doris M. Gotshall - Wife  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  19b. Mailing Address (Street and Number or Run  5209 Kenesaw Street,  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fort Lincoln Cemetery 9/1	College 2  9/2006 E	City or Town, State, Park, MD Oc. Location - City o Brentwood,	20740 r Town, State Mary land
7	Dermit. Departition of the poorts any injures once.		21. Signature of Furieral Service Leannee 22. Name and Address of Facility Ga 4739 Baltimore Ave 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	sch's Fu ., Hyatt:	neral Hom sville, M	e, P.A.
/ 935	box 68/00, beath certificate be executed attending physicien and attending physicien and to the purial-transit and t	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.			Onset and Death  3-1-06
		by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yas 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	Blivery Day Year
7	ecords, F. Claw requires that the as been signed by 2 should be detact	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?  Probably 4 Unknown
-	VICAL RECK iicien: The law r certificate has be	Completed		24a. Was an autopsy perform	No 1 □ Ye	autopsy findings available completion of cause of s 2 8 No
	Ing Phys	Certification; To Be	examiner/ 1	28d. Describe hov	nce 6 Other (Sp w injury occurred	
Ċ	Spital or Attend nours after death neral Director:		4 Homicide  determined  26e. Place of injury. At norme, farm, street, factory, office building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	City or Town,	use(s) and manner a	is stated.
•	To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  29c. License number  20c. 13668	red at the time, dat	d. Date signed (Mor	nth, Day, Year)
	5 St. Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AZHER HOSSAIN 110 49 17, FDGE wood PD. College  31. Date filed (Month, Day, Year)  SEP 1 9 2006	PARICT	10,20740	1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Trem 25 per dvr 8859 9-19-06 vt State of Maryland / Department of Health and Mental Hygiene

For State Registra 29598 006 Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** September 16, 2006 12:20 pm Amelia Gilbert Margaret /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 1641 Williams Avenue Essex If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 💢 F Yrs 3/4/1935 220-30-7154 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f shov other treumatic event, the Madical Examinant mast be notified at 1 Yes 2 No Maryland Baltimore Essex Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 S. A. 1641 Williams Avenue U. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unould be filed within 72 hours after de. th and Mental Hygiene. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 State of Arizona Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be in nent of Health and Mental Eleanor Elizabeth Montgomery 2 Charles Sylvester Bauernschub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mealth a Essex, Maryland 21221 Diane Louise Cook (Daughter) 1641 Williams Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State 9/18 2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licensee eny ir Essex, Maryland 21221 ricchal 1407 Old Eastern Avenue 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BIVENTICULO disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Schenic Cardian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician I for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed δ 8 1 Yes 2. No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 hes autopsy this certificate 1 ☐ Yes 2 X No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after Funerel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 18598 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 206 Balto.m D 2123 Philadel 31. Date filed (Month, Day, Year), 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

06-06956 David Galloway

Please Type or Print in Black Indelible Ink

Manyland / Department of Health and Mental Hygiene

avid Galloway		I- For State Registrar	Certifi	icate of Death	and Mer		Reg. No	2006	2959
Physici Medical Exam	C. 1	1. Decedent's Name (First, Middle,Last)  DAVID WILLIAM GA	LOWAY			2. Date of D Month Septem	eath Day oer 15, 20	Year 0	ime of Death 0522 hrs
and the same of th		4a Facility Name (if not institution, give stree Harbor Hospital	· · · · · · · · · · · · · · · · · · ·	4b. City, Tov	n, or Location			ounty of Death	
Funeral Director			7. Age (In yrs last I	birthday) If Under Months Yrs.	Year If Und Days Hour	s Min	7. 1986	/YYYY) 9. Birthplac Foreign	
w any		Usual Residence of Decedent  10a. State  10b. County		wn or Location					Inside City Limits
Maryland 28a-f show d at once.	ţċ	MD 10e. Street and Number	BALTII	MORE 10f. Zip C	nde	-	10a Citizen	of What Country?	Yes 2 No
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21215-0036  uld be filed within 72 hours after death with the Maryland Mental Hygiene  market other than "natural", or items 23a or 28a-f Sho event, the Medical Examiner must be notified at once	Funeral	11 Marital Status 12.1	Was Decedent Ever in U S Armed Forces?			igin? ( Specify Yes or n, Puerto Rican, etc )	No- 14.	Race - American I White, etc.	ndian, Black,
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0036 within 72 hours a jene iene ier than "natura	Completed	10 TH GRADE	N A	STUDENT				BCHOOL	
21215-0036 ould be filed within 7 Mental Hygiene s marked other than ic event, the Medica	Be Co	17 Father's Name (First, Middle, Last) RAYMOND HICKS				er's Name (First, Middle ANIE GAUC		rname)	
212 rould by d Ment is mari- tic ever		19a. Informant's Name/Relationship (Type, F		19b. Mailing Address	(Street and <b>N</b> u	mber or Rural Route N	lumber, City o		· ·
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altimore, rmit. Pages I ar epartment of He portant: If ite jury or other tr		1 Surial 2 Cremation 3 Re	emoval from State crer	natory or other place)	,	09.22.06		o. mo	, 21010
Baltin permit Pr Departmer Importan		4 Donation 5 Other Specify. 21 Signature of Funeral Service Licensee			Idress of Facili	FUNIERAL			
m ಔವ≗≣ Physician		23a. Part (Inter the disease, or complication	ns that caused the death Do	15151 BAUT	). NATE P	ike, balio.	MD 21	229	proximate Interval
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending I competetly filled in by the fineral director, page 2 should be deached for use as the	Physician/	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of death	<ul><li>Fetal death</li><li>Other (Specification)</li></ul>		pic pregnancy	Mo	onth Day	Year
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∩ of Vi ding Physi a. After this funeral din	-: To	1 Yes 2 No	8a. Date of Injury 28		c Injury at Wor	1	Residence be how injury		
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Hospita 4 hours Funeral		4 V Homicide	(Specify) Townhouse / to the best of my knowledge,		me, date and p			da Street, Balt	imore, IVID
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical Examiner: On t		or investigation, in my c	pinion, death c	occurred at the time, da	ite and place,	and due to the cau	
	Ž	29b. Signature and title of certifier	001.		icense numbe D.C.M.E.	er		e signed (Month, E mber 15, 2006	
ስ		30. Name and address of person who compl	eted cause of death (Item 23						
<del>-</del> 2		Carol Allan, MD Assistant M	edical Examiner 1	11 Penn Street, Ba	altimore, Mi	D 21201			
Regis	tate strar	31. Date filed (Month, Day, Year) SEP 1 9 201	32. Registrar's Signature	O FRANCE					
	_	As and a							

			For State Registrar	State	of Maryla	and / Depa <i>Cei</i>	artment of H	lealth and N Death	Mental Hyg	iene 20	06 29600
	Dhuaisi		1. Decedent's Name (First, Midd	lle, Last)					2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Frederick	Louis	Glaese	er Jr.			Sagtem		5:25 M
	Examin	er	4a. Facility Name (If not institution Baltimore Was	. 3		Ctr.		Location of Death Burnie		4c. County of	Arundel
	Funeral		5. Social Security Number 214-30-4589	6. Sex 1 1 M 2 □ F		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11-7-19	Year)	Birthplace (State or Foreign Country)     MD
	Director		Usual Residence of Decedent						11 / 13	.33	1110
	Aaryland Febow	or	10a. State 10b. Count MD Anne	Arundel	10c.	City, Town or Lo Pasa					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	death with the Maryland me 23a or 28a-f ehow renat be notified at	Funeral Director	10e. Street and Number	h Daad			10f. Zip Code	0.0	1	0g. Citizen of Wh	•
	e 23a	eral	7880 Elizabet		ecedent Ever in	118 12	2112		pecify Ves or No-	USA 14 Baca	- American Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23e or 28e-1 show other treumatic event, the Medical Examiner must be notified at	by Fune	11. Marital Status  1 ☐ Never Married 2 ☒ Ma  3 ☐ Widowed 4 ☐ Divorce	rried 1 XY	Forces?  Sive  Give  Totales:		f Yes, specify Cuba	Specify:	Rican, etc.)	Black	white
2-0(	72 hou	eted	15. Decede	nt's Education est grade complete	ed)	16a. Dece	dent's Usual Occup	ation during most of work	king	16b. Kind of Bus	iness/Industry
21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)		e (1-4or 5+)		kind of work done of DO NOT use retired ricklayer			Constru	ıction
	e filed al Hygi other	Be Co	17. Father's Name (First, Middle	, Last)		1		18. Mother's Nam	ne (First, Middle,	Maiden Sumame	)
Maryland	ould b Menta	To [	Frederick Lo		aeser Sr					.au	
	nd 2 sh lith and 27 is m r treum		19a. Informant's Name/Relation Mrs. Mignonette		/wife		ng Address <i>(Street</i> E <b>lizabet</b> l			MD 211	
Baltimore,	Pages 1 a nent of Hes int: If Item iry or othe		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation			o. Place of Dispo cemetery, crei	sition (Name of matory or other place dee Cemet	ce) 9/2	Date 0/06	20c. Location - C	City or Town, State
altin	permit. Pages 1 Depertment of H Important: If Ite eny injury or ot		21. Signatu of Funeral Service		2.1	/ 22	2. Name and Addre	ss of Facility S	ingleton	Funeral	L Home P.A.
8	80 E E 8		23a. Part 1. Enter the disease,	St. La	Mo136		SEcond A	ve SW G1	en Burni	e MD 210	)61 Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	it only one cause of	on each line.		an c-		or respiratory arr	031,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due Due	to (or as a cons	sequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due	to (or as a cons	sequence of):					
1	be executed iclen and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	to (or as a cons	sequence of):					
8760,	cate be ex obysiclen a the burial	dical E									
9	ertifica ling ph e as th		IF FEMALE:	020 15 1100	a. 4 a a m a a f a c c						
O. Box	or Attending Physician: The law requires that the death certificate death. Director; Atter this certificate has been signed by the ettending r in by the funeral director, page 2 should be detached for use as	Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Li	outcome of pre- ve birth 2 F regnant at time on nknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
ď.	res that thigned by	y Ph	Part II. Other significant condi	tions contributing (	o death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
ords	v require been sig should b	ted t	Pulmor	ary	Em	phy s	sema		1)21 Y	es 2□No 3	3 Probably 4 Unknown
Reco	The law rate has be page 2 sh	mple							24a. Was a autop perfor	med? pr	fere autopsy findings available for to completion of cause of eath?
<u>a</u>	ician: Th certificate ector, pag		25. Was case referred to medic	al				26 Place of Dea	1 ☐ Yes	-	Yes 2 No
Ž	ysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 🐧 No	Magnitale	Inpatient 2	P☐ ER/Outpatie	nt 3 DOA Oth	or	ome 5 Resid		r (Specify)
Division of Vital Records, P.O.	nding Phys th. : After this s funeral di		27. Manner of Death  1 Natural 5 Pence 2 Accident investigation	ling (A	ate of Injury Month, Day Year	28b. Time o Injury	Wor	yat k? Yes 2 ∐No	28d. Describe h	ow injury occurre	d
Divisi	of or Attendial effer death.  I Director: A din by the fu	Certification;	3 ☐ Suicide 6 ☐ Coul-	mined 200. F	lace of Injury - A uilding, etc. (Spe	at home, farm, st	reet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C		al Examiner: On th	ne basis of exam		n conumed at the two				nor as stated and due to the cause(s)
	ro the vithin 2 ro the complet	Med	29b. Signature and title of certification		nanner stated.		29c. Licens	e number		29d. Date signed	(Month, Day, Year)
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_	10		30. Name and address of person	. 1		Item 23a) (Type,	1 /	V 30	iles my	tal D	Glen No Bornie Kin
	Sta	ate	31. Date filed (Month, Day, Yea	1) 200C 3	Registrar's Si	gnature	i cent	200	To the state of th	I TELL IS	INC THEN IN
	Regist	rar	SEP 1 9	2006	de Alexan.	1. Ap	MEL)				

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SEPTEMBER

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EDGAR

			State of Maryland / Dep 1 - State Registrar Ce	partment of Health and Mertificate of Death	lental Hygie	ne 2006	29602
	Dharaisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Reuben R. Hurst		9/1	5/06	3:34am <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) Wash. Adventist Hosp.	4b. City, Town, or Location of Death Silver Spi	cing	4c. County of Death Montgoi	mery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 1/9/2	9. Birthp Coun	lace (State or Foreign try) V
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I			11	Od. Inside City Limits
	a-fah	ctor	MD Montgomery	Silver Spring			1 ☐ Yes 2 🔼 No
	th with the 23a or 28 ist be no	ai Dire	10e. Street and Number 9801 Dilston Rd	10f. Zip Code 2090		Citizen of What Coun	try? SA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow yilying or other traumatic avant, the Madical Examinar must be nutified at ance.	Completed by Funeral Director	11. Marital Status  1 □ Never Married ※ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No Unk. If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify:	
21215-0036	within 72 ho lene. than "natur he Medical	mpleted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Gineer	ing	Construc	
	ld be filed ental Hygis ked other ic avant, th	To Be Co	17. Father's Name (First, Middle, Last) Ingram Hurst	<del>-</del>	e (First, Middle, Maio ne Bri	den Sumame) nkley	
, Maryland	1 and 2 shou Health and M Ism 27 is mar other traumati			ling Address (Street and Number or Rura 1 Dilston Rd Si			
Baltimore,	Pages 1 and nent of Heant of Itam		4 Donation 5 Other (Specify)	ematory or other place)		. Location - City or To Independe	
Balt	permit. Pages Department of Important: If I any injury or once.		21. Signature of Euneral Service Licensee Victor Doda	22. Name and Address of Facility Charles L. Steve 1501 East Fort A	ens Fune Avenue,	ral Home Baltimore	, Inc. e MD 21230
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac of Failure	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e Heart to	ulun		1110/06
	icate be executed physicien and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  c. Due to (or as a consequence of):	tenosis			
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9	artifica ing ph e as th	Med	IF FEMALE:	0			
P.O. Box	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the pact 12 months?  1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date ot delive Month	ry Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobace	co use contribute to th	. /
Division of Vital Records,		Completed	•		24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	Other	(Check only one)		
ō	Phys rrthis aral dii	. To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 Residence 28d. Describe how i	e 6 ☐ Other (Specify injury occurred	"
ion	Attending ir death. ector: Atte by the fune	atior	1)⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Divis	after des Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura (tate)	l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, dea 2 Medical Examinar: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
)	To the within 2 To the complex	W	29b. Signature and title of certifler	29c. License number	29d.	Date signed (Month, I	Day, Year)
105	3	3	30. Name and address of person who completed cause of death (Item 23a) (Type Van Hand - 7600 Carre	a, Print)  OII AUE. TAKO	na Park	e ms	20912
1	Sta Registr		31. Date filed (Month, Day, Year)  SED 1 9 2006  32. Registrar's Signature	Print)  GII AUE. TAKO.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** nna /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🐼 F 220-24-6602 Yrs 78 Director March 2,1928 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 X No Directo Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a 2607 Sykesville Road 21157 USA death v Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Menial Hygiene. int: if item 27 ie marked other then "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 22 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shop Worker Gould Electrical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ George William Korman Elizabeth Brothers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: if item 27 ic or other tra 2607 Sykesville Road, Westminster, MD 21157 Husband James M. Harmon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser. 9/19/06 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD Approximate Interval Between Onset and eath 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician isease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner g physician and certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medicai as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ANNHHARMON Division of Vital Records, P.O. Bu ŏ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) 4☐Pregnant at time of death the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been signification of page 2 should b 2 🗆 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2 🗆 No To the Hospital or Attending Physician: ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 X patient ၉ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai completely and manner stated within 2 29c. License number 7 29 246 29b. Signature and title 29d. Date signed (Month, Day, Year) WASHINGTON HIS WESTMINST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATPARA, MID 224

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 9 2006

ITO APPORT

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AVEND TEM/31, per DR, 0359, 9/19/06 WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 29604 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Hubbel **Physician** 9:45 AM lian 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Square Hospital Center Rosedale 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Vre. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Funeral 1 ☐ M 2 🗑 F 213-20-5296 Yrs Director 81 1925 Maryland June 18. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State or 28a-f ehow troumatic evant, the Medical Exeminer must be notified at Maryland 1 TYes 2 No Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 107 Hampshire Road 21221 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 5 1 ☐ Yes 2 ☑ No Specify: Specify. Completed by 3 X Widowed 4 Divorced White "neturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any njury or other treumatic evant 2005. Be Corsey -Unknown--Unknown-2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denise A. Walker (Niece) 107 Hampshire Rd., Essex, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Mem. Pk. 9/20/06 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee 130 E. Fort Ave.. Baltimore, Md. 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mi mi Physician disease or condition resulting in death) /Medical Examiner linon on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit physician and resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown rasoular diseasea. Was an autopsy perform. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Yes 1 ☐ Yes 🔀 No After this certification funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ampatient Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending within 24 hours efter death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

or Attending Physicien: The law requires that the death certificate be executed

o the Hospitei

Box 68760.

Division of Vital Records, P.O.

4000 Frank

32. Registrar's Signatu

9 2006

Drive Bruto

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 200629605 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician  $P^{M}$ September 14, 2006 3:15 Anna Kathryn Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs. 93 1913 Ohio Director 290-03-8118 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itame 23a or 28a-f show the Medical Examinar must be notified at 1 □Yes 2 図 No Potomac Maryland | Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20854 11215 Seven Lock Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Depertment of Health and Mental Hygiene important: if itam 27 is marked other than "n sny injury or other traumatic event, Ins Mediane. Elementary/Secondary (0-12) College (1-4or 5+) Credit Bureau 12 Head of Personnel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Thomas Daniel Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10664 Muirfield Drive, Potomac, MD (Daughter) Marilyn Taggert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/18/06 4 Donation 5 Other (Specify) Delaware, OH Oak Grove Cemetery 21. Sign, ture of Funeral Service License 22. Name and Address of Facility Robinson Funeral Home Mmein ennes 32 West Winter St., Delaware, OH 43105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Pneumonia 1 Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any labeling to impuritate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of): the attending physicien and the for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation, Hypernatremia, Coagulopathy, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No Congestive Heart Failure page 2 s has autopsy performed? certificate l 1 Yes 2 🔀 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title o September 14, 2006 MD D0060117 30. Name and address of Terson who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr., Rockville, MD 20850 Eric J. Park, M.D.

32. Registrar's Signature

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Registrar

31. Date filed (Month, Day, Year)

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	/Medic Examin		La Facility Name (If not institution, give street daniversity of Mar			Town, or Location of Dea		4c. County of Death	
	Funeral Director		3. Social Security Number 6. Sex 1 1 M 2	3	birthday) If Under Months  Yrs.	r 1 Year If Under 24 Hr Days Hours Mii	(Month, Day, Ye	9. Birthpla Count	ace (State or Foreign
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	pug *		Usual Residence of Decedent  10a, State 10b, Count	v	10c. City, Town or	Location				10d. fnside City Limits
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examerations to rottlied.	by Funeral Director	11. Marital Status  1 □ Never Married 25 Ma 3 □ Widowed 4 □ Divorce	If Yes Give	] No	<ol> <li>Was Decedent of H   If Yes, specify Cubit   1 ☐ Yes 2 ☑ No</li> </ol>	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - A Black, W	
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1	3 1		30. Name and address of person	who completed cause of	death (ftem 23a) (Ty	Charles S.	t. Balto	and a	21204	
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DHMH 17 Rev 1/2001

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 08:30 AM **Physician** September 2006 Elizabeth M. High /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital St. Hgnes Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 TXF Yrs. Director Pennsylvania 84 Feb. 23, 1922 215-22-0453 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Maryland Catonsville Baltimore Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or 21228 1919 Windys Run Road United States death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Factory Worker-Lever Bros. Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked of Ellen Carraher Terrence McCort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Buseck (Daughter) 1919 Windys Run Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or ance. Donation 5 Other (Specify) Meadowridge Mem. Park 9/21/2006 Elkridge, Maryland 21. Six ture of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222
Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Rheumotoid Disease **Physician** ears /Medical Due to (or as a consequence of): Examiner Premaria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1XYes 2 No 3 Probably 4 Unknown Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□ No 1 Yes 2 No 1 TYes LIZABETH filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Mo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide To the Hospital or 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

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State

Wilkens

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Basliaran

3455

32 Registrar's Signature

Carried .

31. Date filed (Month, Day, Year) SEP 1 9 2006

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September, 17, 2006

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		,	1 - For State Registrar	State of I	Maryland	/ Depa	artment of rtificate o	Health a	and Mental Hy	Reg. No. 200	6 29610
	Physicia /Medic	al	Decedent's Name (First, Middle Et)     La Facility Name (If not institution	oert Lauron		r, Sı		, or Location o	2. Date of De Month Septemb	Day Year	6 4:00 A M
	Examin Funeral		Gilchrist Home 1 5. Social Security Number	for Hospice	Age (In yrs. las			rson ar   II Under 2	24 Hrs. 8. Date of Bir Min. (Month, Da	Bal th y, Year) 9. B	timore Co.  inthplace (State or Foreign Country)
	Director		212–10–7307 Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	O Yrs.		20177	March 2	2, 1916   Ma	ryland  10d. Inside City Limits
	or 28s-1	Directo	10e. Street and Number	ltimore		44	10f. Zip Code	s Mills	5	10g. Citizen of What C	1 □ Yes XXNo Country? USA
36	filed within 72 hours after death with the Maryland Hygiene. Iffise then "naturel", or items 23s or 28s-f show ent, the Medical Examiner must be notified at	by Funeral Directo	2817 Baublitz Ro	12. Was Decede Armed Force 1 \( \subseteq Yes \) X If Yes, Give	es? ☑No	1		f Hispanic Orig uban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Am Black, Wh	nerican Indian,
1215-0036	within 72 hours ine. ihen "naturel" is Medical Ex	Completed b	15. Decedent (Specify only highes Elementary/Secondary (0-12)	Year or Date t's Education st grade completed) College (1-4		(Give life.	dent's Usual Occ kind of work dor DO NOT use reti	ne during most ired)		16b. Kind of Busines Glenn L. Westingho	s/Industry Martin &
_	e d a b	To Be Co	12 17. Father's Name (First, Middle, John Walter Heft			Dia	CSINALIA	18. Mothe	r's Name (First, Middle, ie Ophelia	, Maiden Surname)	
e, Mary	1 and 2 sho Health and em 27 ts m ther traum		19a. Informant's Name/Relations Frank G. Dean 20a. Method of Disposition	hip <i>(Typ</i> e, <i>Print)</i> (Son in Law	7) 1	36 Cl	ng Address (Streenargeur sition (Name of		r or Rural Route Number Reistersto		136
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signature of Juneral Service	(pecify)	. cem	oll U	natory or other p	ırch Cei	m 9/18/06	·	
Ba	Dep Dep pmi ony		23a. Part1. Enter the disease, or shock, or heart lailure. List	complications that cau	sed the death.	36	531 Fall	s Road	itz Funeral Baltimore cardiac or respiratory a	, Maryland	21211 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a/			d de	ment	iA		Onset and Death  Years
_	cate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a consequer						
O. Box 68	it the death certifica by the ettending ph tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal de t at time ol deat	ath 3	Ectopic pregnar Other (specify)			23d. Date of d Month	elivery Day Year
rds, P	The law requires that the te has been signed by that age 2 should be detached.	ξ	Part II. Other significant condition	ons contributing to deat	h but not resulti	ng in the u	nderlying cause	given in Part I.	1	obacco use contribute Yes 2 No 3 F	to the cause of death?  Probably 4 Unknown
		Completed							24a. Was autor perfo	osy prior to death?	autopsy findings available completion of cause of s 2 \( \sum \) No
Division of Vital	ding Phy. h. After this tuneral d	atlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner ol Death  1 Natural 5 Pendin investig	Hospital: 1  Inp		VOutpatier 9b. Time o Injury	28c. In W	Other: 4 Nu			ecity) tospice
DIVIS	i di di	Certification:	3 Suicide 6 Could in 4 Homicide determine	ined 289. Place of building	, etc. (Specify)		eet, lactory, offic		City or To		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  2 Medical  29b. Signature and title of certifier	ng Physician: To the be Examiner: On the basi and manner	est of my knowle s of examination stated.	edge, deat n and/or in	n occurred at the vestigation, in my	time, date and y opinion, deat	d place, and due to the h occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
8	7 3 7 8		30. Name and ad less of person	my fully	of death (Item 23	Э За) (Туре,	D2	5205	19	Sytenle	-14,2006
	Sta Registr		31. Date filed (Month, Day, Year)	32. Agg	istrar's Signatur	Cun Cun	se St.	palts	. Md Zi	20%	as stated. Le to the cause(s)  Inth, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth September 16, 2006 **Physician** 10:20 PM Mabel R. Hartman /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6165 Deanna Drive Sykesville Carrol1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year Birthplace (State or Foreign Country) Funeral Months Days 1□ M 2√2 F 89 Yrs. 215-10-6096 Director February 07,1917 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipertment of Health and Mental Hygiene. In cortant: If Ifem 27 is marked other than "neturel" ~ ... ary njury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Director Maryland Sykesville Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 United States of America 6165 Deanna Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛣 No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) C. & P. Telephone Co. Service Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pauline Bertholot Sidney Remington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Nephew) 6165 Deanna Drive, Sykesville, Maryland 21784 Donald R. Pahl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 09/20/06 Randallstown, MD 21133 Mt. Olive U.M.C.Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 Rellner M00333 23a. Rant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical chetrockie lung disperse Examiner Due to (or es a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that let its and the cause) Due to for as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? actory dispuse 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) menia 058641 Soptember 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PESKU: 110 M1) 21234

Registrar **DHMH 16 Rev 6/95** 

State

truc

31. Date filed (Month, Day, Year)

Montai

4400

32. gistrar's Signature

06-07020 Loyd D. Hendrix

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certin	ficate of	Death			F	Reg. No.	200	16 2961
Physicia	an/	1. Decedent's Name (F	irst, Middle,Last)							2. Date of Dea	ath Day	Year	3. Time of Death
edical Exami		Loyd Dail								Septemb	er 17, 20	006	1215 hrs
		4a. Facility Name (if no		street and number	er)		b. City, Tov		ation of Deal	th		County of Death	
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212 suld be Ment mark	To B	19a Informant's Name				19b. Mailing	Address			Rural Route Nu			e, Zip Code)
AD 2 shc 1 and 27 is mati		Mr. Michae	1 Hendr	ix / son		316	Whitf	ield	Road;	Baltim	ore,	MD 212	28
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	UNPENDED		AMENDED									
8760, tificate be ang physicials as the buria	ıΣI	IF FEMALE:		23c If yes, outo	come of pregna						23d	Date of deliver	у
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Box e death of the atten- ed for us	sic	1 Yes 2 No 9	9 Unknown	9 Unknown		5 Oth	her (Specify	')					
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1)		30. Name and address Carol Allan, M				<sup>3a)</sup> 11 Penn S	Street Ra	ltimore	MD 212	01			
							Janobi, De		, 1410 212				
S Reais	tate	31. Date filed (Month)	P 1 9 20	Ub Co	trar's Signature	· Apr							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 11:46 AM Ray Hamilton 9 15 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Ye 2-9-1920 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 ☐ F 86 212-16-4358 YIS Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location il Hygiene. other than "natural", or items 23a or 28a-f ahow vant, the Medical Examinar must be notified at 10d. Inside City Limits MD Anne Arundel Pasadena Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1808 Hampton Chase Court 21122 Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shop Steward Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental James Ray Hamilton Hazel White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heeith a Mrs. Tracey Riccobene/daughter 1808 Hampton Chase Crt., Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if its any injury or ot ance. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 9/19/2006 Stevensville. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee 1 Second Ave SW Glen Burnie MD 21061 MO1459 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEREOSCIEROTIC CARDIOVASCULAR DISEASE YE ARES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL DISEASE, ANEMIA OF 1 Tes 2 No 3 Probably 4 Unknown DISEASE, LEGG-PENTHES DISEASE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: after death.

Diractor: After this certific 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 25 No 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after de To the Funaral Diracto completely filled in by th 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and Attle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)31136 wellan no SEPTEMBER 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 9005 KILBRIDE RD, BACTIMORE, MD 21236 WALLACE MID C. 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2006 Registrar

			1 - For State Registrar	State of Ma	ıryland /	Departr <i>Certifi</i>	ment of H icate of L	ealth and D <i>eath</i>	Mental Hy	giene Reg. No. 20	06 2	9614
	Physici		1. Decedent's Name (First, Middle, L RASHEM)		ton	ý			2. Date of De Month	Day	Year	of Death
	/Medio Examin Funeral		0 - 1 - 7 - 0	ive street and number)	SPITA (In yrs. last)	JL 4b	BA-L Under 1 Year	Location of Dea	Ith  ICE  S. B. Date of Bir	4c. County o	f Death  9. Birthplace (Sta	ate or Foreign
	Director		217-86-5253	1□M 2[X]F	33	Yrs. Mo	onths Days	Hours Mir	09 08		Country) \	1D
	aryland ehow	7	10a. State 10b. County		•	own or Location	on				1	de City Limits Yes 2 ☐ No
	r 28a-1	Funeral Director	MD NA  10e. Street and Number		ватс	imore	Of. Zip Code			10g. Citizen of Wi		
	ath with	raiD	1805 Clifton					21217		U.S.		
2-0036	urs after de al', or Items Exeminer r	þ	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2X N If Yes, Give Year or Dates:			Decedent of Hi s, specify Cuba Yes X□ No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify:	- American India , White, etc. Black	
21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department: if Item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at ODGe.	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5		(Give kind life. DO N		luring most of w	orking	16b. Kind of Bus	of	
ام 2	e filed al Hygie other	Be Co	12th grade 17. Father's Name (First, Middle, La	na		Dat	a Entr		ame (First, Middle	Social , Maiden Surname		:e
Maryland	should be nd Mental i marked c	100	Rufus Hilton-F		1	Oh Mailing As	desan (Street e		a Leona	er, City or Town, S	that 7in Code)	
_	alth and 2 st		Rufus Hilton-F			•			Ba <b>lti</b> mo		2 <b>1217</b>	7
Baltimore,	Pages 1 ament of He ant: If Item ury or othe		20a. Method of Disposition   ↑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control of		ceme	-	ry or other place	e) Park 9/	Date /18/06	20c. Location - C		
Ball	Depart Depart Import eny in		21. Signatur of Funeral Service Lig	Dumu		430	me and Addres ch F/H O Waba	ash Ave	e, Balt:	imore, 1	Md 212	215
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that caused by one cause on each lin	the death. D	o not enter th	e mode of dying	g, such as cardia	ac or respiratory a	rrest,		imate   Between and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to/(or as a		e of):		ARCTI	1			
	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	20 Ny	ARY	AR	TERY	DIS	EASE		
	nd nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	co. Co	R	PUL	MOX	JA LE	=			
58760,	icate be executed physicien and s the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a	a consequenc	ce of):						
_	entificat ding phy se as th		IF FEMALE:	23c. If yes, outcome	of oregnancy							
P.O. Box	uires that the death certificate be executed signed by the attending physicien and doe detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal dea		opic pregnancy ner (specify)			23d. Date Mont	,	Year
_	w requires that been signed b should be det	Ď	Part II. Other significant conditions	contributing to death bu	it not resulting	g in the underl	lying cause give	en in Partl.		obacco use contrib Yes 2 🗆 No 3		of death?
Division of Vital Records,	12 00 CA	Completed							24a. Was auto perfo 1 ☐ Yes	psy pri	ere autopsy finding ior to completion eath?	of cause of
Zita Zita	slcian certificitiector	o Be	25. Was case referre o medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Outpatient 3	Othe	ne:	eath (Check only o		(6	
ion of	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	F 1	27. Mann Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	v 28t	o. Time of Injury	28c. Injury Work	4 Nursing		dence 6 ⊡Other how injury occurred		
Divis	s after de s after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, . (Specify)	farm, street,	factory, office		28f. Location ( City or To	Street and Number wn, State)	r or Rural Route I	Vumber,
)	e Hospii 24 hour e Funera letely fille	Medicai (	29a. Certifier 1 Criting (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination	dge death upp and/or investi	our ed at the tim gation, in my op	ia, date and plan pinion, death occ	and due to the curred at the time,	couse(s) and man date and place, an	net as stated nd due to the cau	se(s)
	To the To the complex	Me	29b. Signature) and title of certifier	Q Char	7	. X	29c. License			29d. Date signed		
,	4		30. Name and address of person wh	o completed cause of de	Path (Itom 23a	a) (Type, Print	000	0 5 0 5	ا کا	Septem RS Ho	Ku 1.	2,2001
)	/		ROSITA R	CRUZ	- M	. D	130	N SI	= Cou	RS HO	SPIJ.	44
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 9 20		r's Signature	Month	0					

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		For State of Maryland / Department of State of Maryland / Department of Certificate of		1ental Hygler Reg. l	711115	29615
Physicia		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
Physicia /Medica	al	7,7,7000	n, or Location of Death	SEPT	15 2006 4c. County of Death	
Examine	er		IMORE		NI	7
Funeral Director		5. Social Security Number  200-09-4985  6. Sex 1 M 200F  7. Age (In yrs. last birthday)  Wonths Day  Usual Residence of Decedent		8. Date of Birth Month, Day, Yes June 6, 19		nplace (State or Foreign untry)
the Maryland r 28a-f ehow	tor	10a. State 10b. County N/A 10c. City, Town or Location	more	<i>&gt;</i>	:	10d. Inside City Limits 1 Yes 2 □ No
death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	100. Street and Number Castle MOOR Rd, 101. Zip Cod	21244		Citizen of What Co	4
ō 2 3	۾	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive Year or Dates:	of Hispanic Origin? (Spi Cuban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	ncan Indian, o, etc.
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene mportant: if Item 27 ie marked other then "naturel", or Ite nny injury or other traumatic event, tra Medical Examina page.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  N A	ne during most of work tired)	ing 16b	. Kind of Business/I	,
laryland 212: 2 should be filed within and Mental Hygiene. ie marked other then aumatic event, trem	Be	17. Father's Name (First, Middle, Last) Den nion Gregory	18. Mother's Name	e (First, Middle, Maid	den Sumame)	
faryla 2 should and Men ie marke	ဥ	19a. Informant's Name/Relationship (Type, Print)	1	01 2		- 1./
Baltimore, Maryla permit. Pages 1 and 2 should Department of Heelih and Men Important: if Item 27 is marke any injury or other traumatic once.		20a. Method d/Disposition  1 ABurial 2 Cremation 3 Removal from State	lemoor K		Location - City or	Z 1 Z 44  Town, State
iltimor nit. Pages artment of 1 ortant: if the		4 Donation 9 Other (Specify)  21. Signature of Funeral Service License 22. Name and Ad		21-06 H	ob uties	ma.
Balt permit. Depart importu		Jany / March Gary P.		neral Hon	ne Baet	0, md, 2, 1229
Physician /Medical Examiner	<b>.</b>	23a. Party of the disease, or complications that caused the death. Do not enter the mode of a shock of heart failure. List only one cause on each line.  Immediate cause (Final disease of condition resulting in death)  a. HEMORROGIC SHOC Due to (or as a consequence of):  Sequentially list conditions, if any leading to immediate	-K		SYM	Approximate Interval Between Onset and Death  On Constant On Cons
876(cate be physicie the bu	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d				
.O. Box 6. the death certification by the attending ached for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify, 9) Unknown			23d. Date of deli Month	very Day Year
rds, P. (	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobacc	1 /	the cause of death?
$\mathcal{HHBEL}$ , Vital Records, sician: The law requires to certificate has been signs fector, page 2 should be	Completed	,		24a. Was an autopsy performed	? death?	topsy findings available completion of cause of
Wital F Vital F sician: Th certificate	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Other	h (Check only one)	a 570# - /2	
n of n of ng Phys	$\vdash$	TA inpatient 2 ENVOLIDATION 3 DOA	4 🗆 Nursing Ho	ome 5 Residence 28d. Describe how in		erty)
DIVISION OF VITAL  Division of VITAL  To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director, it	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,
Divi	Medicai Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only one)	e time, date and place, ny opinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the comple	Mec	A	ense number	29d.	Date signed (Monti	n, Day, Year)
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	217700	, JG	1.0 =	2000
Stat	ie.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ve, Dali	linere	IM) 2	1229
Registra		SEP 1 9 2006 Bloom & Sparks				

	•	1- For State of Maryland /	Department of Health and N Certificate of Death	lental Hygien Rag. No	2000 20010
Physic		1. Oecedent's Name (First, Middle, Last)	Jones	2. Date of Death Month Da September	3. Time of Death 01:40 pm
/Medi Exami		4a. Facility Name (If not institution, give street and number)  Sinai Rospital of Baltin	4b. City, Town, or Location of Death	40	c. County of Death
Funeral Director		5. Social Security Number  6. Sex 1 M 20 F  7. Age (In yrs. last b)	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year NOV. 12, 13	9. Birthplace (State or Foreign Country)
Aaryland f ehow	ō	1.	wn or Location  BA 170.		10d. Inside City Limits 12√Yes 2 ☐ No
with the Manual of the Manual	Director	10e. Street and Number 2621 E MWRA ST.	10f. Zip Code	10g. C	tizen of What Country?
iole, Indi yidilid 2.12.13-0000 ges 1 and 2 should be tiled within 72 hours after deeth with the Maryland t of Health and Mental Hyglene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	/ Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes (1974)	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
in 72 hours n "natural",	Completed by	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	Kind of Business/Industry
Lai ylailla Z IZ I	Be Com	Elementary/Secondary (0-12)  13 Ad  17. Father's Name (First, Middle, Last)	Nuksing Aid 18. Mother's Nam	e (First, Middle, Maide	of 05 p
2 should be and Mental is marked c	Tof	1 1 2 1	Db. Mailing Address (Street and Number or Flui	-	
Pages 1 and 3 ment of Health int: If Item 27 Lry or other tr		20a, Method of Disposition 20b. Place of cemeter 20b. Place 20b. P	ery, crematory or other place)	Date 20c. I	ocation - City or Town, State
Dentill Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	22. Name and Address of Facility BETTS - GARCINE	Hone Co	Timps Mills MD
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence P) PP MM	in abdominal L	raM	10
cuted nd ransit	Examiner	ff any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events c.	в от):		
of ou, cate be executed chysicien and the burial-transit	dicai	resulting in death) Last  Due to (or as a consequence d.	e of):		
The COLOS, F.O. DOX 00/00,  The law requires that the death certificate be executed as bean signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2≅No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
law requires that: as been signed by	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
10 G G G	Completed	,		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
VICAL icien: T certificet ector, pa	Be	25. Was case referred to medical examiner?	Othor	th (Check only one)	
ding Phys h. After this of	tion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b.	Dutpatient   3   DOA   Other: 4   Nursing House	ome 5 Residence 28d. Describe how inj	
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
he Hospit in 24 hours he Funera pletely fille	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge 2 Madical Examiner: On the basis of examination and manner stated.			
To t To t	2	29b. Signature and title of certifier	29c. License number RES CCC	0	ate signed (Month, Day, Year) 15106
10		30. Name and address of person who completed cause of death (Item 23a Hamed Mirnals, Sinad	RES VOU (Type, Print) HUSPITAL OF BAH And	meie 240	1 W. Belvedur Ave
Si Regis	tate trar	31. Date filed (Month, Day, Year) SEP 1 9 2006	fall	-	12 2.213

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amend item 20b per fh 9859 9-21-06 vt
State of Maryland / Department of Health and Mental Hygiene
State Amend item#11, perFH, 9859, 9/19/06 TT Certificate of Death

Reg. No. 2006 Reg. No. 2006 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JEMISHEY 1215 AM M Lodo 16 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA CTY UNIVERSITY OF MARYLAND MED CIR BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Pountry)

Naryand 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1□M 20F Min 60-212-60-378 2 Usuel Residence of Decedent 3782 Yrs. Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itama 23a or 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 2902 Was Decedent Ever in U.S. Amed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Blac Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. United Brotherhood Elementary/Secondary (0-12) College (1-4or 5+) of Carpenters Dente 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 end 2 should be fill tment of Heelth and Mental H tant: If item 27 is marked other. 19a. Informant's Name/Relationship (Type, Print) (Mower) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Disposition (Name of American property) .21 4 Kosa amar 0 or other 20b. Place of Dispo Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5/2006 Department of important: If any injury or once. 5 Other (Specify) 4 Donation rematory 21. Signature of Fune al Service Livensee 22. Name and Address of Facility
JOSCAN L. Russ
2222 W. North tome BA Q.M alelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTERSTITIAL WNG DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). by Physician/Medical Examiner Aftar this cartificate has been signed by the attending physician end funeral director, page 2 should be deteched for use es the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient Certification; To 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury i efter death. f Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours el To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and Itle of certified 29c. License number 29d. Date signed (Month, Day, Year) MelEAN MD 1744 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 ST MD 2120 27 62 BALTIMORE 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Johns Virginia 9 2006 14 12:p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore 900 West Lexington Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1 ☐ M 2X F Yrs 216-18-2730 80 03 26 26 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 XYes 2 No Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 900 West Lexington Street 21223 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: 3 ☐Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) House Keeper Levindale Nursing 8th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Dobson Myrtle Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 North Ellamont Street, Balto, Md 21216 Donna M. Dyson-Daughter 20b. Place of Disposition (Name of cometery, registery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen Estre C... Cemetery 2. Name and Address of Facility -Church 9/21/06 Ivytown, Md 31. Signature of Funeral Service Licenses March F.H. West mala 4300 Wasbash Avenue, Baltimore, Md. 21215 23a. P.rt1. Enter the disease, or complicitive is that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imp ediate Cause (Final di ease or condition CARDIO MY OPATHY ISCHEMIC sulting in death) Due to (or as a consequence of): AMDIAC 1712 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILURE 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Page Department of Importent: if eny injury or once.

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

Be ၉

**Funeral** 

Director

in then "naturel", or iteme 23s or 28e-f ehow the Madical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours atler ment of Heelib and Mental Hygiene.
ent: if item 27 is marked other than "naturel; or ite ury or other traumatic event, the Madical Examinating or other traumatic event, the Madical Examinating or other traumatic event, the Madical Examination

Baltimore, Maryland 21215-0036

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Examiner Completed Be

been signed by the attending physicien and should be detached for use as the burial-transit

this certificate

After

death.

within 24 hours of

To the

director,

filled in by the efter death

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Certification;

Medical

or Attending Physicien:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical IF FEMALE: δ

25. Was case referred to medical examiner?

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☑ No

27. Manne of Death

2 ☐ Accident

3 ☐ Suicide

29a, Certifier

4 / Homicide

24a. Was an autopsy performed 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

26. Place of Death | Check only ne Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

BALTIMORE

28c. Injury at Work? 1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number MD

29d. Date signed (Month, Day, Year) 2006

MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

827 LINDEN AVE. MOHAMMAD ORGIZI ES FAHANI

9 2006

32 Registrar's Signature

28a. Date of Injury (Month, Day Year)

State Registrar

DHMH 17 Rev 1/2001

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		4	For State	State of Marylan	d / Depa	rtment of F	lealth and M	ental Hygie	ne2006	29619
68	- P	₫ <sub>0</sub>	Registrar     Decedent's Name (First, Middle, Last	)		incate or	Douth	Reg. 2. Date of Death		3. Time of Death
	Physici		Thomas	Leon		Joh	nson	C	Day Year Zool	4:52 PM
<b>X</b>	/Medic Examin	ai -	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	th
			Sinsi Hospital o			Baltin				
	Funeral		5. Social Security Number 6. Se	]M 2□F	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Co	thplace (State or Foreign ountry)
1000	Director	<u></u>	187-24-0484 Number of December 187-24-0484	7.3				03 20	33	MD
	yland now		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	MD NA	В	altim	ore				1X Yes 2 No
	or 28	Oire.	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath w	Funeral Director	3603 West Fores		lst F		216	adv Voc ar No	U.S.	
	item item	-une	11. Marital Status  1 Never Married  Married	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☑ No			lispanic Origin? (Spe an, Mexican, Puerto f	Rican, etc.)	Black, Whit	
036	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes <b>X</b> ☐ No	Specify:		Specify:	Black
5-0036	n 72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show affical Examinations be notified at	Completed	15. Decedent's Ed (Specify only highest grad		16a. Deced	lent's Usual Occup	ation during most of working	16t	. Kind of Business	/Industry
21		mple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d)		Naval A	andomy.
121	lled w tygier ther ti		12th grade  17. Father's Name (First, Middle, Last)	na	Trans	portati	on Speci 18. Mother's Name	allou		cademy
and	d be f	o Be	William H. John	son			Ruth E.	_	,	
Maryland	ges 1 and 2 should be filed within 1 to Health and Mental Hygene. If item 27 is marked other than " or other treumatic event, the Mai	ဥ	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street			ty or Town, State, a	Zip.Code) 21216
	and 2 salth a n 27 is		Ethel Johnson-W	ife	3603	West F	orest Pa	rk Ave	Apt 1st	Floor
ore,	of Health of Health litem 27 i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. F	Place of Dispo semetery, cren	sition (Name of natory or other pla		ate 200	. Location - City or	Town, State
altimore,	Page ment ant: if ury o		4 Donation 5 Other (Specify	Ga	rriso	n Fores	st Vet. 9	/18/06	Owings	Mills, Md
Balt	permit. Pages Department of I Important: If ite any injury or of		21. Signature of uneral Service Licen:			Name and Address R/				
9	40240		23a, Part1, Enter the disease, or comp	lications that caused the deat			ash Ave,			21215 Approximate
			shock, or heart failure. List only o	ne cause on each line.						Interval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)	a. Acute ( Due to (or as a conseq	Cerebr	vs sculs	Accide	ut		17 days
	Examiner			Ischen		rdi my				1 mouth
340		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	1				
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8760,	icate be executed physician and s the burial-transit	EX EX	resulting in dealth, cast	Due to (or as a conseq	ence of):					
87	physi physi	dical		d						
Box 6	that the death certificated by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
	death a atter	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		]Ect <i>o</i> pic pregnanc ] Other (specify) _	y		Month	Day Year
P.0	t the by the tache	hys	9 Unknown	9□ Unknown						
	8 5 9	by P	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.			the cause of death?
ord	w require been sig should b	ted						1 🗆 Yes	2 □ No 3 □ Pi	robably 4 Unknown
Records,	aw as b	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>E</u>	ate pag							1 Yes 2	death? No 1 ☐ Yes	2 2 No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	TEDIO	Ot	26. Place of Death		o (70) - (8	
of		-	27. Manner of Dea	28a. ate of Injury	28b. Time of			8d. Describe how	e 6 Other (Spe injury occurred	iciry)
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2 □No			
Division of	r Attendi er death. rector: A by the fu	tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str	eet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or R	ural Route Number,
Ö	ital or irs aft ral Di	Cer								
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death ation and/or in	occurred at the tweetigation, in my	me, date and place, a opinion, death occurre	and due to the caus ad at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29d.	Date signed (Mont	th, Day, Year)
	r ≯ ⊢ ŏ		San VITULA	10		DØ	\$6329	3 C	· 1	D. 2001
	WX1		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,				11 Junes	12,2006
	Q,		Sidney Nelson, 1	completed cause of death (Iter Y MD Si wath 32. Registrar's Sign	ospital	of Bult	more			
77	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		_			
5%	Regist	ar	CED 1 9 2006	A CALLAN SON	1					

State of Maryland / Department of Health and Mental Hygiene 2006 29620 For State Registra Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 09 13 2006 9:37p. Johnston /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Nursing Home N/A Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Yrs. 216-32-0182 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28e-f show vent, the Medical Exeminar must be mailied at 1 X Yes 2 ☐ No Directo NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 4405 Garrison Blvd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 XWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker House 12th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 Is marked other any injury or other traumatic event, 0003. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Michael Hayes-Son 4405 Garrison Blvd, Baltimore, Md 20b. Place of Disposition (Name of cametery, crematory or other place)
Metro 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/15/06 Baltimore, Md Crematory Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician EREBROVASCULAR ALC I DENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEPTICEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No CONGESTIVE HEART 24a. Was an cate has t this certificate 1 Yes 2 PNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DN6 ္ပ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059107 m.D 14-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTER DRIVE, REISTERSTOWN MD 2-1136 UMA BUSINESS 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 15, 2006 7:30 A M Richard F. Jeffers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner #321 Catonsville 717 Maiden Choice Lane Baltimore 8. Date of Birth (Month, Day, Year) March 7, 1912 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Min. 1**X** M 2□ F Months Hours Director 94 Illinois 443-40-4808 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumatic event, if a Medical Examinar must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland Baltimore Catonsville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 717 Maiden Choice Lane #321 21228 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alice VanWinkle George Jeffers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 717 Maiden Choice Laen #321; Catonsville, MD 21228 Rebecca Jeffers 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/8/2006 Arlington, Virginia Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, inc. 21. Signature of Funeral Service Licenses ocola 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** O days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit ed by the attending physicien and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ryshyseny 1 Yes 2 No 3 Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate hes 2 No 1 Yes or Attending Physicien: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Menth, Day, Year) den Chone Can, Catonwelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2006 Registrar

06-06822 Steven A. Ring UNK UNK

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

INC OINC		For State  legistrar	Certificate of		tai riygic	Reg I	No. 201	06 2962
Physician	/	Decedent's Name (First, Middle,Last)	Vina			te of Death onth Da ptember 1	ay Year	3 Time of Death 0414 hrs
Medical Examine	1	Steven 4a Facility Name (if not institution, give street and	Number) King	b. City, Town, or Location		ptember 1	4c County of Death	
		University of Maryland		Baltimore			NA	
Funeral Director	L	5 Social Security Number 6 Sex 1 M 2 1	7. Age (In yrs. last birthday)  19  Yrs.	If Under 1 Year If Under Months Days Hours	Min	11-10-	MM/DD/YYYY) 9 Bir Foreig 1986 Co	
any		Usual Residence of Decedent  10a State 10b, County	10c. City, Town or Location	on				10d Inside City Limits
**	ا ة	Md. NA	Balti					1 XYes 2 No
th the Maryland 23a or 28a-f sho ngiffed at once.	Director	10e. Street and Number		10f. Zip Code		10g	Citizen of What Coul	ntry?
with the		302 Ilchester Avenue		21218  Decedent of Hispanic On			USA 14 Race - Amer	ican Indian, Black,
or item	Funeral	X Never Married 2 Married 1 Ye	2 <b>X</b> No	es, specify Cuban, Mexican	i, Puerto Rican	, etc.)	White, etc	
within 72 hours after death with the Maryland giene her than "natural", or items 23a or 28a-f sh Medical Examiner must be noffied at one	≥ -	Widowed 4 Divorced If Yes, Give or Dates.  Decedent's Education (Specify only highest g	Year 1	Yes 2 X No specify 's Usual Occupation (Give	kind of work di	one 16	Specify: B1  Sb. Kind of Business/	ack
5-0036  ted within 72 hours after tygiene "matural", other than "matural", the Medical Examiner.	Completed		(1-4 or 5+) during mo	ost of working life DO NOT				
Nothin iene er than	ᇍ	12th grade	Dis	sabled	r's Name (First	Ministra Mai	NA	
P = 5 = 4	ညို ရှိ	17. Father's Name (First, Middle, Last)  Ronald	Davis	la Mottle	Angela		Ki	ng
	ᆰ	19a Informant's Name/Relationship (Type, Print )		Address (Street and Nur				
s I and 2 sh of Health an If item 27		Valmaree Williams Gr 20a Method of Disposition	reataunt 302 I	lchester Ave	nue, Ba	e 2	ce, Ma. 2 Oc Location - City or	Z1218 Town, State
Tore ages 1 and of Hi		1 Burial 2 Cremation 3 Remova	I from State crematory or oth		9-20-6	06	Dundalk,	Mf.
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other trauman.	İ	4 Donation 5 Other Specify  21. Signature of Funeral Service Licensee	22. N	ame and Address of Facilit	Mar	ch F.H	. East	
	4	23a. Part I. Enter the disease, or complications that		101 E. North				21202 Approximate Interval
Physician /Medical	ļ	failure. List only one cause on each line.	wound to chest	., J,				Between Onset and Death
Examiner			s a consequence of)					
San Care	ē		s a consequence of).					
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60, ate be exe physician	Medical	UNPENDED AMENDE					22d Date of deliver	
3876 rtificate ling phy as the		23b. Was decedent pregnant in the past 12 months?		tal death 3 Ectopi	c pregnancy		23d Date of deliver	y Day <b>Y</b> ear
Box 687  e death certific  the attending p  ed for use as th	Physician	4 Pr	egnant at time of death 5 Oth	ner (Specify)				
that the d		Part II. Other significant conditions contributir	g to death but not resulting in the u	inderlying cause given in P	art I.		cco use contribute to	J
S, P.(	ed by	-			— [,	1 Yes		bably 4  Unknown utopsy findings available
cords,	Completed			<del></del>	— ľ	autopsy performe	prior to	completion of cause of
Vital Rec		25. Was case referred to medical		26 Place of Death		Yes 2	No 1 Y	es 2 No
Vita yssician this cer directo	o Be	examiner? 1 ✓ Yes 2 No	Inpatient 2 FR/Outpatient	3 DOA Other	Nursing Hor	me 5 Re	sidence 6 Othe	r.
Division of Vital Records, P.O rate or Attending Physician: The law requires that the rate death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	on: T	1 Not and Cook	ate of Injury onth, Day, Year) 10, 2006 28b. Time of I	njury 28c. Injury at Wor	Sub	Describe hov	v injury occurred	
ision Attenorate death	icati	2 Accident Investigation 28e. F	Place of Injury - At home, farm, stree	54.824 SEE - SEE - SEE		Location (Stre	eet and Number or Ru	ural Route Number, City
Divisior pital or Attenc ours after death eral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Spec	Multi-Family Apt.		370	or Town, Stat 9 8th Stree	<sup>e)</sup> et, Baltimore, <b>M</b> o	d.
	Medical C	Check only	best of my knowledge, death occur sis of examination and/or investigat					
To S	Be	29b Signature and title of certifier	er stated.	29c. License number		- 1	9d. Date signed (Mo	
		Theodor U. King	The mess.	O.C.M.E.		;	September 11, 2	:006
7	j	V	cause of eath (Item 23a) stant Medical Examiner	111 Penn Street, Ba	altimore, M	D 21201		
	ate	31 Date filed (Month, Day, Year) 32	. Registrar's Signature	anti		-		
Regist	rar	SEP 1 9 /UUb	Maritan No fresh					

	_1	State Registrar	State of Marylar		ment of Hea icate of De		lental Hygie Reg  2. Date of Death		29623
Physicia	-76	Decedent's Name (First, Middle, Last)     KATHLEEN	).	KIRBY		•	Month SEPTEMBER	Day Year 2006	3:00 A.M.
/Medic		4a. Facility Name (If not institution, give str			o. City, Town, or Lo		PHI THIBHK	4c. County of Deat	
Examine	ar	FOREST HILL HEALTH		TER	FORES'	r HILL		HAR	FORD
Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age (In yrs.			Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Dec. 25	9. Birt	hplace (State or Foreign untry) DWA
pu k	- I-	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location	on				10d. Inside City Limits
faryla show		Md. Harford			urchville	2			1 ☐ Yes 2 No
the N 28a-	rect	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
3a or	0	206 White Thorn W	ay		21028	3		U.S.A.	
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Important: If term 27 is merked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinational be multiled at 9000.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in L Amed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		s Decedent of Hispa as, specify Cuban, I Yes 2 🖾 No 3	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
vithin 72 houndle	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind	t's Usual Occupation of work done duri NOT use retired)	on ing most of work	ang	b. Kind of Business	/Industry
iled wil Hygien ther th		5+ 17. Father's Name (First, Middle, Last)		Leach		3. Mother's Nam	e (First, Middle, Ma		
weld be fill Mental Hy arked oth	ă	James D. O'Leary				Rowena	Hanson		
shoul nd Me mark	2	19a. Informant's Name/Relationship (Type	s, Print)	19b. Mailing A	Address (Street and	Number or Rui	al Route Number, (	City or Town, State,	Zip Code)
and 2 sh alth and 127 is n er traun		Robert Kirby/husb	and					le, MD 210	
of Head of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b.	Place of Disposition cometery, cremate				c. Location - City or	
Pag ment tant:		4 ☐ Donation 5 ☐ Other (Specify)	St	. John's		9/18/		Hydes, Md	
permit. Pages Department of Important: if it any injury or o		21. Signature of Funeral Service License	eeus	610	W. MacPl	hail Roa	ed. Bel A	el Air, In ir, Md. 2	1014
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the dea e cause on each line.  Due to (or as a conse	etect		t	or respiratory arres		Approximate Interval Between Onset and Death
Examiner put Junean Laurent	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):					
ate be shysici the bu	dical Ex	resulting in death) Last	Due to (or as a conse	quence of);					
death certif e attending d for use a:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	cc. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3□Ec	etopic pregnancy ther (specify)			23d. Date of de Month	livery Day Year
4 6 6	Ď	Part II. Other significant conditions cont	inbuting to death but not re		orlying cause given			cco use contribute t	o the cause of death?
sician: The law requires thet the centilicate has been signed by the irector, page 2 should be detache	Completed	CVA					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ician: ertific ector,	Be	25. Was case referred to medical examiner?	neoital:		Other		th Check only one		
Physic r this o	٠ <u>۲</u>	1 ☐ Yes 2 No		ER/Outpatient 28b. Time of	3 DOA Other:		ome 5 Residen	ce 6 Other (Spe	ecify)
ding f h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury a Work? M 1 ☐ Ye	s 2 □ No		,,	
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special	nome, farm, street	, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier it Certifying Phys (Check only one)	ician: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death or nation and/or inves	ccurred at the time, stigation, in my opin	date and place lion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier			29c. License r			d. Date signed (Mon	•
1		1 Davel 59			D35	297	•	Storant	Per17,200C
12		30. Name and address of person who cou	mpleted cause of death (Ite			L AIR, 1	1D. 2101	4	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	artis				

Registrar

**Physician** 

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**Funeral** 

Director

item 27 is marked other then "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at

I Hygiene.

12 should be fi h and Mental F 7 Is marked ot

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Department of Health an
Important: If item 27 is
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**Physician** 

/Medical

Examiner

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To the Hospital of within 24 hours at To the Funeral D

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Examiner

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Certification:

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Maryland 21215-0036

Baltimore,

SEPTEMBER 14,

DHMH 17 Rev 1/2001

Grante

2300 DULANEY VALLEY RD.

32. Registrar's Signature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) SEP 1 9 2006

			For State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of F	lealth and I <i>Death</i>		iene 200	6 29625
			Decedent's Name (First, Middle, Last)			·		2. Date of Death	h	3. Time of Death
н	Physicia		Obrvant Ke	ENNER				Sentemb	er 16 200	
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of Death		4c. County of De	
			University of Mary	land Medical	Conter	Baltir	more (	Pity	N/	A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(Year) 9. B	inthplace (State or Foreign Country)
	Director		255-60-0536	M 20 F 65	Yrs.	Months Days	Hours Will.	Time 18		GA
	D .		Usual Residence of Decedent	10.0						1
	arylar show	_	10a, State 10b. County	10c. Cir	y, Town or Lo					10d. Inside City Limits
	Ba-f	Director	MD MA	150	Hins					1 X Yes 2 No
	in the	Dire	10e. Street and Number			10f. Zip Code			0g. Citizen of What	Country?
	be filed within 72 hours efter death with the Maryland Hygiene. All Hygiene. do other than "natural", or items 23a or 28a-f show avent, I're Medical Examinar must be notified at		1402 Hollins St		,	21233			JSA_	
	tems fems	Funerai		<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, hite, etc.
9	s efte	by Fi	1 Never Married 2 Married	1 ∐ Yes 2 No If Yes, Give	1	☐Yes 2⊠ No	Specify:		Specify:	1 1
5-0036	ure!	D D	3 Widowed 4 Divorced	Year or Dates:						Slack
Ÿ	nat adic	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of Busines	ss/Industry
212	withir	E D	Elementary/Secondary (0-12)	College (1-4or 5+)			-/	0	100	H School System
2	Hygie ther nt, m		12 TH GRADE 17. Father's Name (First, Middle, Last)	years	Coun	selor	18 Mother's Nar	me (First, Middle, M		y schief Jaiche
ä	B a b	Be	ND V				١ .	c .	_	
Ξ	should be filed ad Mental Hygi marked other imatic event, ii	ဥ	19a. Informant's Name/Relationship (Typ	e Print)	19h Mailin	a Address (Street	Luvenia and Number of Bi	1	City or Town, State	Zin Code)
Maryland	0 e e			300				a GA 30		, LIP COOR
	s 1 end 2 f Health itsm 27 l		20a. Method of Disposition	Ster)		sition (Name of	, Dragust		20c. Location - City	or Town. State
altimore,	Peges net of int: If it iry or o		1 M Burial 2 ☐ Cremation 3 ☐ Re	moval from State	emetery, cren	natory or other plac	1 6			
트			4 Donation 5 Other (Specify)		lar Gre				Augusta	GA
Ba	permit. Departimportimportismo injudication.		21. Signature of Funeral Service License	0.			ss of Facility			
			230 Borth Estay the discount or complia	Treeve		151 Balto			rote, MD	Approximate
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.	n. Do not ente			correspiratory arre	<b>35</b> 1,	Interval Between Onset and Death
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	/Medical Examiner		Tooling in douin,	Due to (or as a conseq	uence of):					
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0	ed sit	ine	Sequentially list conditions, I arry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or da a conseq	werne ory					1
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×	thet the death certifi ed by the ettending detached for use as	/Me	IF FEMALE:	ic. If yes, outcome of pregna	ancv				224 Date of	4-15
Вох	etten for u	Physician/M	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)	y		23d. Date of o Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	10atii 5_	Cities (specify)				
Δ.	thet t		Part II. Other significant conditions con-	ributing to death but not res	ulting in the ur	nderlying cause gry	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Records,	9 D 0	d by			•	, , ,		1.□ Ye	es 2 No 3	Probably 4 Unknown
ğ	w requir been si should	Completed								
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_					_				No 1 Y	es 2 No
Vital	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:		1 0#	200	ath (Check only of	2	
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Ľ	After funer	<u>6</u>	1 Viatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe no	w injury occurred	
Division of	tend Jeath tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Disease ( Leises - A) 6			]Yes 2□No	006 1		0. /0
<u>≥</u>	or Attendent efter deat Director:	Ħ	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	ome, rarm, str fy)	eet, factory, office		City or Town		Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours eiter death. To the Funeral Director: After this certifical completely illed in by the funeral director;		29a, Certifier 1 Certifying Phys	ining. To the best of and	nuladas 4					
	To the Hospital within 24 hours e To the Funeral I completely filled	edical	(Check only 2 Medical Examin one)	ician: To the best of my known:  On the basis of examination and manner stated.	wiedge, death ation and/or inv	vestigation, in my o	me, date and place opinion, death occi	e, and due to the caurred at the time, da	ause(s) and manner ate and place, and c	as stated. due to the cause(s)
	ithin of the orthodornal	Mec	29b. Signature and title of certifier	and marrier stated.		29c. Licens	se number	25	9d. Date signed (Mo	onth, Day, Year)
	£ ₹ 8			KANAA	411	1 A114	170434	B17291	0 1	1 . 11 DAX
7			July X	10000	M.	U. ITUT	1/0	0117/0	septem	ner 16, 200%
	12	VIII (and a shadow	30. Name and address of person who con	npieted cause of death (Iter	п 23а) (Туре.	Erint) Carro	on Ci	Ralli	noore 1	MA DIDAT
		100	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature /	J. 011.6	KIR ST	DOM	IVIOIT, I	10 20
	Sta Regist		SEP 1 9 200	A 1 / / / /	The state of the s	sell)				

State of Maryland / Department of Health and Mental Hygiene 200629626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Elizabeth Francis Kofron 1:40P September 13,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Care Ctr. Baltimore Co. Dundalk If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M X F 220-05-0437 May 15,1915 Maryland Director 91 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Dundalk Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1911 Van Buren Road United States 21222 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 35 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 'Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important; if Item 27 is marked other it any njury or other treumatic event, ILA 2008. Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) Ukn. 17. Father's Name (First, Middle, Last) Ukn. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1938 Stanhope Road Dundalk, Maryland Patricia Pierorazio (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/16/2006 Baltimore, Maryland 4 ☐ Donation \_5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signatur of Ineral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner signed by the attanding physician and it be detached for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 mont Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 **P**No this certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 D No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Aftar the funeral 27. Mann Toeath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 5 Pending t Yes 2 No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Fo the Hospital 12 Conflying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the nauso(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ப்ப m 23 aprily 10 - A RITCHIE HIGHWIT AND 21225 MAR 31. Date filed (Month, Day State 9 2006 Registrar

			For State Registrar	State o	of Marylan	d / Depa	artment o	of Health a of Death	and Me		giene 2 (	006	29627
ī	Physicia	an	1. Decedent's Name (First, Middle,							2. Date of Dea	ERPay18,	386x	3. Time of Death 10 : 50 A
	/Medic	al		Kerns	mbari		4h City To	wn, or Location		P. I CIAD			
ł	Examin	er	4a. Facility Name (If not institution, Saint Josep			iter			owso			y of Death Balt:	
	Funeral Director		5. Social Security Number 212–34–7053	5. Sex 1 □ M 2 🖾 F	7. Age (In yrs. 87	last birthday) Yrs.	Months D	ear If Under lays Hours	Min.	B. Date of Birtl (Month, Day Jan. 22	, Year) 2, 1919	9. Birthpla Countr	ce (State or Foreign Virginia
			Usual Residence of Decedent							Jan. 22	., 1515		
	arylan ehow	<u>_</u>	Maryland Balti	more		y, Town or Lo OWSON	cation					100	d. Inside City Limits 1 ☐ Yes 2 No
	the M	ecto	10e. Street and Number			02011	10f. Zip Co	ode			10g. Citizen of	What Countr	
	3a or		509 E. Joppa Ro	ad				1286			USA		, .
	eme 2	Funeral Directo	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deceden	t of Hispanic Ori Cuban, Mexican	igin? (Spec	ify Yes or No- ican, etc.)	14. Ra	ce - America	
0	s after	by Fu	1 Never Married 2 Marrie  3X Widowed 4 Divorced		2 <b>X</b> No		1 □ Yes 2/C					y: Whit	
200	Phour		15. Decedent's	Education		16a. Dece	dent's Usual C	Occupation			16b. Kind of E	Business/Indu	istry
<u> </u>	thin 72 e. n.	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (		(Give	kind of work of	tone during mos etired)	st of working	7	Cataly	st Pos	oarch
7	be filed within 72 hours after death with the Maryland at Hygiene. And Hygiene defect then "naturel", or iteme 23a or 28a-f show ad other then "saryland man the notified at event, the Madical Examinar man be notified at		6			Facto	TY PLO	duction					earch
yland	a la b ♥	To Be	17. Father's Name (First, Middle, L. Will Kerns	ast)				1	rtha	Long	Maiden Suma	me)	
Mary	od 2 1th a 27 is		19a. Informant's Name/Relationshi Gloria Sheesley	<sub>p (Type, Print)</sub> Daughte	er	19b. Maili 4410	rg Address (S Falls	treet and Numbe Bridge	or or Rural Dr. [	Route Numbe Jnit E	r, City or Town Balti	o, State, Zip ( More,	<sup>Code)</sup> MD 21211
ore,	es 1 ar of Hea if item or other		20a. Method of Disposition	3 □Removal from	State	emetery, cre	osition (Name matory or othe	r place)	Da		20c. Location		
palitimo	Pag tment tent: I		4 Donation 5 Other (Sp.	ecify)	Me		emator		9/22/2		Catons		MD
g n	permit. Pages: Department of h Importent: If its any injury or of		21. Signature of Funeral Service L	B H	uss)	22	Burgee 3631 F	Henss of Facility Henss Roal Alls Roa	Šeitz ad, Ba	Funera altimor	al Home e, Mar	yland.	21211
			23a. Part1. Enter the disease, or c shock, or heart failure. List o			h. Do not en	er the mode o	f dying, such as	cardiac or	respiratory ar	rest,		Approximate nterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	OSIS (or as a conseq	uence of):						-	
	Examiner		Sequentially list conditions,	b. ——	(or as a conseq NARY 1	RACT	INFEC	TION					
	ed sit	lner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(UI da d CUII364	uence of).							
	be executed iclen and burial-transi	Examin	that initiated events resulting in death) Last	c	(or as a conseq	uence of):							
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	ertifica ling ph	Med	IF FEMALE:	220 14 1100 011									
X Q	death certificate e attending phys d for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 Live	tcome of pregna birth 2 ☐ Feta nant at time of d	Ideath 3	Ectopic pregr				1	ate of delivery onth E	∕ Day Year
		hysi	9 Unknown	9□ Unkr	iown								
ds, r	law requires that the death certifics as been signed by the attending pt 2 should be delached for use as the	ρ	Part II. Other significant condition CONGESTIVE HEAR			ulting in the u	nderfying caus	se given in Part I	I.	23e. Did to	20		cause of death?
COL	aw require s been si 2 should t	Completed	STROKE							24a. Was		Were autops	sy findings available
Ä	0 2 0	ШO								autop perfor 1 Yes	med?	death?	pletion of cause of
VITA	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11.0000				1 -	e of Death	Check only or	*		
6	Phys rthis ral di	7.	1 ☐ Yes 2 No 27. Manner of eath	Hospital: 1 28a. D te		ER/Outpatie					lence 6 Ot		
0	ting Afte	atlon	1 Natural 5 Pending 2 Accident investiga	(Mor	nth, Day Year)	Injury	м	Injury at Work?					
UIVISION	그 북 후 ㄷ	Certification:	3 Suicide 6 Could no 4 Homicide determin	280. Place	e of Injury - At hi ling, etc. (Specii	ome, farm, st	reet, factory, o	ffice	28	3f. Location (S City or Tow	Street and Num m, State)	ber or Rural	Route Number,
	Hoe Fun Bely	Medical C	29a. Certifier (Cneck only one)  1X Certifying 2 Medical E	Physician: To the xaminer: On the and mar	e best of my kno basis of examina nner stated.	owledge, deat ition and/or in	h occurred at t vestigation, in	he time, date ar my opinion, dea	nd place, an	nd due to the o	cause(s) and made	anner as sta , and due to t	ted. he cause(s)
	To the Howithin 24 h To the Fur	Me	29b. Signature and title of certifier	1	<del>/)                                    </del>		29c. L	icense number			29d. Date sign	ed (Month, D	ay, Year)
	d		1	Kon				37254			9/18	3/06	
	h '		30. Name and address of person w	I M D	760	neir	Print) ER, DRI	VF TO	าพรตพ	- MARY	LAND 8	21204	
	Sta	te		· · · · · · · · · · · · · · · · · · ·	Registrar's Signa	ature	Come	7 tum 1 tu	u v v turturt t N	7 - 11 11 1	2001 I T 44/ h	ns, also desses Tail "I"	
	Registr	ar	31. Date filed (Month, Day, Year) SEP 1	A 7000	P. Cherry								

			For Stete Registrar	State of M	laryland / D	epa <i>Cer</i>	artme <i>tifica</i>	nt of H <i>te of L</i>	ealth a Death	nd M		giene Reg. No.		6	2962
	Dharini		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea	ath Day	/ Year		3. Time of Death
	Physici /Medio		LOIS I. KRAUC	Η							SEPTEM		16, 200	06	9:11 A.M
	Examir		4a. Facility Name (If not institution, give	street and number	-)		4b. City	, Town, or	Location of	Death		4c.	County of Dea	ath	
			GILCHRIST CENTER					TOWS					BALTIN	10RI	₹.
	Funeral		5. Social Security Number 6. S	9x 7.A □M 2527 F	ge (In yrs. last birt.	- "	If Unde Months	Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Da	h v, Ye <i>ar</i> )	9. Bi	rthplac ountry	e (State or Foreign
	Director		214-26-0875 Usual Residence of Decedent		79	Yrs.		L.,			7/25/	1927	PEN	INS:	YLVANIA
	land		10a. State 10b. County		10c. City, Town	or Lo	cation							10d	. fnside City Limits
	Many it	ō	MD BALTIMO	2F	701	NSO)	N.T							i	1 ☐ Yes 2X No
	28°	Director	10e. Street and Number	ш	101	W.D.O.		ip Code				10g. Citi	zen of What C	ountry	?
	3a o		8501 PLEASANT PL	ATNS ROAD				2128	6			,	TIC A		
	ms 2	Funeral	11. Marital Status	12. Was Deceden	Ever in U.S.	13. V	Nas Dec	edent of Hi	spanic Orig	in? (Spe	city Yes or No		USA 14. Race - Am		
9	hours after deeth with the Maryland tural', or tleme 23a or 28e-f ehow al Examiner must be notified at	Ē	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2  If Yes, Give					n, Mexican,	Puerto	Rican, etc.)		Black, Whi	ite, etc	÷.
8	raf.	d by	3X Widowed 4 □ Divorced	Year or Dates			i 🗆 res	2 □XNo	Specify:				Specify: N	HI	ſΈ
21215-0036	72	Completed	15. Decedent's Ed (Specify onfy highest gra		16a.	(Give	kind of w	ual Occupa	luring most	of workin	ng	16b. Ki	nd of Business	/fndus	stry
2	within ene. then"	Id I	Elementary/Secondary (0-12)	Cotlege (1-4or	· ·	life. [	OO NOT	use retired,	)						
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and	b d la b	Be									(First, Middle,	Malden	Sumame)		
Ž	hould d Mer marke matic	ဥ	ALFRED JACOBSON  19a. Informant's Name/Relationship (7)	ivon Printl	10h	Mailia	a Addros	o (Street o		A HO		- Cinc	- Taura Ctata	7:- 0	- 4-1
Maryland	nd 2 she lith and 27 is m												r Town, State,		000)
	1 6 E		DEBORAH A. KRAUCH, 20a. Method of Disposition	DAUGHTER	20b. Place of	Dispos	sition (Na	E AVE			INGHAM,		21236 cation - City of		. State
altimore,	m O		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		DULANE)	y, cren Z Vz	natory or ALLE	other place Y MEM	1	- /	1				
	世界を言う		21. Signature of Funeral Service Licen			API	DENS Name a	nd Addres	s of Facility	9/21	/2006	COCI	KEYSVIL	LE,	_MD
Ba	Deprint Permitted		13								JOHNSC D. TOWS				Æ, P.A.
			23a. Part1. Enter the disease, or comp	olications that cause	ed the death. Do n								MD 21	A	pproximate
	Physician		shock, or heart failure. List only a Immediate Cause (Final	one cause on each		000	·~~/	-1000		aut-	m M11	1+1	0-0		tervaf Between nset and Death
	/Medical		disease or condition resulting in death)	a. Due to for a	s a consequence of	()·	W 1	My	e,a	CUI	C mo	- )((	cax	- (	days
	Examiner			Cerch	rovasc	ال	as:	$\mathcal{A}$	SOO	De .	e mu			u	COB
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence o	of):								1	1300
	cuted nd ransi	Examin	Cause (Disease or injury that initiated events	C											
ő	e exe		resulting in death) Last	Due to (or a	s a consequence o	of):									
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9		Me	IF FEMALE:	220 14								T		-	
Bok	death certifi e ettending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death			regnancy				2	23d. Date of de Month	livery Da	ıy Year
Ö	the e	Physician/Me	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	at time of death	5 🛴	Other (s	pecify)							,
۵.	requires thet the death certifeen signed by the ettending hould be detached for use at		Part II. Other significant conditions of	ontributing to death	but not resulting in	the ur	nderlying	cause dive	n in Part I		23e. Did to	bacco u	se contribute t	o the o	cause of death?
ds,	95 PB	d by	Coronary ar	ory d	some	_	, ,					es 2[			1.0
Ö	> 40	ete									04: 146:		0.15 144		
Rec	has has	ompleted									24a. Was a autop		prior to death?	compl	findings available letion of cause of
e		e Co	25. Was case referred to medical								1□ Yes	5000	1 ☐ Yes	2[	□ No
Vital Records,		00	examiner?	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Out			OA Othe	-		(Check only or				HOSPICE.
o		): To	27. Manner of Death	28a. Date of Inj	ury 28b. T	ime of		28c. Injury Work	4   14013		e 5 Resid		Other (Spe	ecity)	limine
Ö	Attending r death.	atlo	1 DAtatural 5 Pending 2 Accident investigation	(Month, D	ay rear) In	ijury	м		? ′es 2 □ N	0					
Division	Attender death ector:	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	289. Flace of it	njury - At home, far	m, stre	et, facto	y, office		2	8f. Location (S	treet and	d Number or R	ural R	oute Number,
Õ	s effe	Cer		building, e	itc. (Opecity)						City or Tow	n, 3iaie)	,		
	To the Hospitel or Attenwithin 24 hours effer deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exert	sicien: To the besiner: On the basis	t of my knowledge,	death	occurred	at the tim	e, date and	place, a	nd due to the d	ause(s)	and manner a	s state	id.
	To the H within 24 To the F complete	Med	01107	and manner s	tated.										
	T V T V	-	29b. Signature and title of certifier	0	1000		29	c. License	number		1	29d. Date	signed (Mon	th, Dej	v, Year)
	6		everade,	100	ulle	2_		A 0	264	->		04/	116/0	00	6
4	7 1			completed cause of	death (Item 23a) ( $6601~N$ .			00(1	a-d	12	rolf	$\Delta i$	) 2.0	20	4
	Sta	te	31. Date filed (Month, Day, Year)	7.	trar's Signature	م ر	rau.	-cs 07	1001	/ 10	000	. ~	17	-0	J
	Registr		CED 1 0 260		K	dos	well		,						

		1	For Amend #8 Per State of Maryland Department of Health and M  - State Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia	_	Calvin Howard Leary	Month /	6- 06 4:48am
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death
	Examine	3	Franklin Square, Hospital Center   hosedale		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 His. Months Days Hours Min.	8. Date Opth (Month Day, Yea	9. Birthplece (State or Foreign Country)  O 2 / Moneyal and
	Director		217-16-0108 15M 2 F 82 Yrs. Mortilis Days Hours	JUL <del>19</del> , 1	.924   Maryland
Pac	* *	- I	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
100	faho	<u>ة</u> ا	Maryland Baltimore Essex		1 ☐ Yes 2 X No
q	death with the maryland rms 23a or 28a-f show r must be rediffed at		10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
1	23a o		342 Savannah Road 21221	anifu Vac or No	USA  14. Race - American Indian,
	ems er m	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
מ ל	hours after turni', or ite	by Fi	1 □ Never Married 2 ⅓ Married 1 ⅙ Yes 2 □ No If Yes, Give 1 □ Yes 2 ⅙ No Specify: Year or Dates: 1941-45		Specify: White
3	atural cal E		15 Decedent's Education 16a. Decedent's Usual Occupation		, Kind of Business/Industry
וֹ <u>ח</u>	hin 72 9. 9n "n Medi	Completed	[Specify City Migrest glass somplet]  life. DO NOT use retired)		Dalbimana County
Maryland 21215-0050	ygien ygien t, Ibe	S	Firefighter  18. Mother's Nam	e (First, Middle, Mai	Baltimore County  den Sumame)
	d off	Be	17. Pathers Name (Prist, Micore, East)	Schmidtm	
7	should be filed within 72 ind Mental Hygiene. I marked other then "net umatic event, the Medic	ဥ	Howard Leary  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		
Z Z	and 2 sleath and 2 sleath and 27 is referenced		Eileen Ethel Leary/Wife 342 Savannah Road Es	ssex, MD 2	
<u>ق</u>	Hea Hea Hem Other	1 3	20a. Method of Disposition	Date 200	c. Location - City or Town, State
E	Pages nent of int: If it iny or o		1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)  Metro Crematory, Inc. 9/16		Baltimore, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the wayran Department of Health and Mental Hygiene Practical; or Itama 23a or 28a-f show Important: If item 27 is marked other then "netural; or Itama 20a or 28a-f show amy injury or other treumatic event, the Medical Examiner must be notified at anoning.		21. Signature of Funeral Service Licensee  Edward A. Gregorchik  22. Name and Address of Facility Cre 299 Frederick Road	Baltimor	re, MD 21228
	Physician and Medical Examiner burist-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):  Cardio resulting a consequence of):	ding st	Interval Between Onset and Death
.O. Box 66	ath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
٥.	ires that the de signed by the d be detached	by	Parti. Other significant contains		cco use contribute to the cause of death?  2 No 3 Probably 4 Donknown
Records,	sician: The law requir certificate has been si irector, page 2 should	Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 \( \text{Yes} \) 2 \( \text{No} \) No
of Vital		BeC	25. Was case referred to medical 26. Place of De	ath (Check only one)	
∑ <	Physician: this certific ral director,	2	1 No Proposition 2 ER/Outpatient 3 DOA 4 Nursing to	28d. Describe how	ce 6 Other (Specify) vinjury occurred
	ling P	lon	27. Mann r of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury at Work? 1 Natural 1 Natural Investigation		
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ical Ce	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  1 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cau urred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
_	To the I within 2 To the I complet	Medical	N Manglas Kan Done 7 61.	>	d. Date signed (Month, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Ahmad ABU - Ghaida 900 Franklin 3quare  31. Date filed (Month, Day, Year)  SEP 19 2006  32. Registrar's Signature	Drive Br	1 to more. Md 21737
. *		tate	31. Date filed (Month, Day, Year) SFP 1 9 2006  32. Registrar's Signature		<u> </u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar 2006 29630 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** OUPEN 2:15 September 15 2006 JAME S /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSpita Cit THE JOHNS HOPKINS more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F MD 02-28-1950 Director 214-56-3447 56 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE **EDGEMERE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7221 ORTH ROAD 21219 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes ZANIO If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced BLACK Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSEMAN SOCIAL SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES LOUDEN, SR. 2 THELMA D. MERCER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21229 ANNIE LOUDEN/WIFE 503 MT. HOLLY ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 9-21-2006 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. morton 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition Physician Sminute ASystole resulting in death) /Medical Due or as a consequence of): Examiner Sep 515 5 DAYS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a nonsacrience of Examiner I Records, P.O. Box 68760,  $\frac{C}{V}$  The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 28c, Injury at Work? 27. Manner of Death 28b. Time of fnjury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number September, 15, 2006 RES-000 MP PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WOLFE Street BANMONE MD 21287-9106 600 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State SEP 1 9 2006 ME GISRUS Registrar

			1 - For State Registrar	State of M	larylan	d / Depa <i>Cer</i>	irtment of tificate of	Health a	and Men	tal Hyg	iene 20	06	29631
	Dhysisi	<b>.</b>	1. Decedent's Name (First, Middle, Las	t)						Date of Deat Month		Year	3. Time of Death
	Physici /Medio		Margaret Lovel							ptembe	er 18,20		6:00PM M
)	Examir	er	4a. Facility Name (If not institution, give		)		4b. City, Town				4c. County o		
			8208 Spring Botto 5. Social Security Number 6. Se		ge (In vrs. )	last birthday)	P1	kesvil	24 Hrs. 8 F	Date of Birth		imor	
Н	Funeral Director			<b>X</b> M 2□ F	92	Yrs.	Months Day		Min. Ap	Month, Day,	7ear) 5,1914		ace (State or Foreign ry) gland
			Usual Residence of Decedent						[F		,		
	urylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation					10	d. Inside City Limits
	8a-f	cto	MD Balti	imore		Pikes	sville_						1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of W		ry?
	23e	erai	8208 Spring Bott	om Way 12. Was Deceden	t Ever in II	S 13 1		1208	igin? (Specify	Vac or No-		JSA - America	in Indian
	Item Item	Š	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces	?	3. 13. 1	Vas Decedent of Yes, specify Cu	iban, Mexicai	n, Puerto Rica	n, etc.)		, White, e	
936	urs af	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			I∐Yes 2⊠XN	o Specify:			Specify:		White
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's Ec			16a. Deced	lenf's Usual Occ	upation	et of working		16b. Kind of Bus	siness/Ind	ustry
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work don OO NOT use reti				D 111		
	ygien ygien nt, the	S		4		ыа	ille Tra	7			Braille		ety
pug	2 should be filed within 72 hours after dea and Mental Hyglene. Is marked other then "naturel", or Items reumatic event, the Medical Examiner ra	Be	17. Father's Name (First, Middle, Last) Unknown		16			18. Moth			Aaiden Sumame	9)	
ž	d Mer narke	2	19a. Informant's Name/Relationship	Tuno Print)	Mo	rris	a Address (Stre	ot and Numb	Lilli		Barkham , City or Town, S	State Zin i	Codel
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 ie marked other then "naturel", or iteme 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at										ville, N		1208
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 to eny injury or other tre		Jane Andreadakis 20a. Method of Disposition	Niece	20b. P	lace of Dispo	sition (Name of		Date		20c. Location - 0		
Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		В	-	natory or other p remation	1	9/20/0	6	Нат	mnete	ad, MD
薑	permit. F Departm Importar eny injur		21. Signature of Funeral Service Licen	·	/2		. Name and Add				Reisters		
ã	Depariment of the control of the con		Stephen	M - 4	zuk.	E E	line Fun	eral H			rstown,		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death	n. Do not ent	er the mode of d	ying, such as	cardiac or res	spiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Chron		tretu	plnon	13500	. ( 2				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a			1	01.20					
	Examiner	_	Sequentially list conditions,	b									
	B / 4 #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	иөпсө оту:							
	al-trar	хап	that initiated events resulting in death) Last	c Due to (or a	s a consequ	uence of):			-				
8760,	icate be executed physicien and contract transit	icai E	l	d									
89	The law requires that the death certificate be executed ate has been signed by the ettending physicien and agge 2 should be detached for use as the burial-transit	edic											
Box 6	eath certific ettending pl I for use as t	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnar	nou.			23d. Date		•
-	deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnanf			Other (specify)				Mon	th [	Day Year
P.0	that the de led by the e detached t	Phys	9 🗆 Unknown										
	ires that signed t d be det	by	Part II. Other significant conditions c	ontributing to death	but not rest	ulting in fhe ui	nderlying cause	given in Part I	1.				cause of death?
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	icate									1 ☐ Yes 2			2 8 No
of Vital	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?	Hospifal:		5010:		)than	e of Death (Ch				
of	ding Physician: The I h. After this certificate ha funeral director, page	7 To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of In		ER/Outpatien 28b. Time of	3000	4 🗆 14			once 6 Othe		)
o	Attending r death. ector: Alter by the funer	랿	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injury		lork? ∐Yes 2. ☐	No				
Division	Attendi	1100	3 Suicide 6 Could not be 4 Homicide determined	289. Place of I	njury - Af ho	ome, farm, str	eet, factory, offic	е		Location (St	reet and Numbe	r or Rural	Route Number,
Ö	s afte	Certification:	4 Tromiside	building, e	экс. ( <i>эрвс</i> п)	y)				City of 10Wi	i, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes niner: On the basis and manners	of examina	wledge, death tion and/or in	occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, and o ath occurred a	due to the ca t the time, da	ause(s) and mar ate and place, a	ner as sta nd due to	ited. the cause(s)
	To the within To the Comp	Σ	29b. Signature and title of certifier		186			nse number			9d. Date signed	•	,
	1		I mu so		(IVI)		0	5059-	2	5	extender	19,	2006
	5		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type,							
	)		Todd Baldanza	10753	Falls 1	Road S	ville 225	Lih	exilly, A	malan	1		
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 9 201	Hegis	rrars Signa	iure A	Print)						
			OFL T 0 500	The state of the s		to the same	15-00						

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Dejuan Lumpkins 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Y September 15, 2006 2132 hrs ual **Medical Examiner** 4a Facility Name (if not institution, give street and number 4c County of Death Town, or Location of Death Baltimore Saint Agnes Hospital 9 Birthplace (State or Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 5. Social Security Number **Funeral** Foreign Country) Hours Director 1 X M Usual Residence of Decedent 10d Inside City Limits Yes 2 No or 28a-f show notified at once should be filed within 72 hours after death with the Maryland Director 10g Citizen of What Count 10e. Street and Number  $\mathcal{N}$ mers 14. Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11. Marital Status 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X No Yes Yes 2 No specify: Divorced If Yes, Give Year Specify Widowed is marked other than "natural", itic event, the Medical Examiner þ 16b Kind of Business/Industr 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Baltimore, MD 21215-0036 of Health and Mental Hygiene 17. Father's Name (First, 18. Mother's Name (First, Middle, mia Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a, Informant's Name/Relationship (Type, Print.) 2 Catonsville mother other traumat Pages 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 2 Cremation 3 -22-06 Cremater noulle Important: injury or oth metro Other Specify Sign Fred Boetlo, md, 21229 Reneval Home Approximate Interval Between Onset and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Fil e. List only one cause on each line /Medical a Gunshot wounds(2) to the abdomen Imme ate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 the Hospital or Attending Physician: hin 24 hours after death 26 Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 DOA Other Inpatient 2 V ER/Outpatient 3 1 V Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28c Injury at Work' 28d. Describe how injury occurred 27. Manner of Death Certification: Subject was shot FOUND: Natura Yes 2 🗸 No Pending the f Director: Sep 15, 2006 2050 hrs Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Winters Lane, Catonsville, MD within 24 hours a To the Funeral I determined (Specify) Outside of a building 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Che one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) September 16, 2006 n O.C.M.E. MID 30. Name and address of person who completed cause of death (Item 23a) 2 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 9 2006 15 6:05 PM Nancy C. Lenfestey 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 F Yrs. 232-64-5223 87 4/8/1919 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes XXNo Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21234 USA 2825 Cub Hill Rd. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes XXNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify white 3€3€Vidowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry

Approximate Interval Between Onset and Death

vears

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

rthan "naturel", or items 23a or 28e-f ehov the Medical Examiner must be notified at 2 should be filed within 72 hours efter of and Mental Hygiene. Maryland 21215-0036 permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Important: If item 27 ie marked other th any injury or other traumatic event, the once. Baltimore,

**Physician** 

/Medical

Examiner

MD

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by Funeral

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**Funeral** 

Director

28e-f ehov

**Physician** /Medical Examiner

ed by the ettending physicien detached for use as the buria

Be Completed by Physician/Medical

Certification: To

cal

29b. Signature and title of certifier

Hospital or Attending Physician: filled in by the funeral death. 24 hours efter deal completely within 2

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed Veterinarian 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Bond J R Caldwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2825 Cub Hill Rd. Baltimore, MD 21234 Barbara Lundell- friend 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel – Bel Air September 1 ☐ Burial 3 ☐ Cremation 3 ☐ Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) 17, 2006 21. Signature of Pineral Service Licenses 8800 Harford Rd. Parkville, MD 21234 22. Name and Address of Facility Evans Funeral Chapel Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition . Arterioscientica cardiovascular resulting in death) Due to (or as a consequence of) Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part RIGHTHIP 1 ☐ Yes 2 ☐ No PNEUMONIA ASPIRATION 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation -at home 1 ☐ Yes 2 🗖 No 2 Accident
3 Suicide 4:30P 12006 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2825 CUB Hill Rd/BalloMD 21234 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide nane whitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

lendall, RFaulkner MD/6601 N. Charles St/Bolto MD

eller

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

25643

State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician Anna H. Laughlin 7:25 Α 14 2006 September, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center
5. Social Security Number 5. Sex 7. Age (In yrs. las Towson #Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2XXF 211-24-4996 79 15,1927 Pennsylvania Director Usual Residence of Decedent the Marytand 10d. Inside City Limits 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyghene. Important: if itsm 27 is marked other than "natural; or items 23a or 28s-f show any injury or other traumatic svant, if a Madigal Examinar must be notified at once. 1 ☐ Yes 2XXNo Maryland Baltimore County Timonium Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 United States 405 Plumbridge Court Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Allied Signal Elementary/Secondary (0-12) Colfege (1-4or 5+) Clerical Supervisor of Law Dept. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Agnes Miller John Lewis Haas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Refationship (Type, Print) 27 Lovett Court, Timonium Maryland, 21093 Mrs. Linda Carroll (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel | Sep.15,2006 Forest Hill, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr. P.A. 21. Signature of Funeral Service Licensee 2325 York Road, Timonium Mar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failfure List only one cause on each line. 2325 York Road, Timonium Maryland, 21093 Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Carcino matos Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 Cher (specify) 4☐Pregnant at time of death P.0. sete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificete 1 ☐ Yes 2√☐ No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2√XNo 2 ER/Outpatient 3 DOA this After the 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending To the Front effect death.

To the Funeral Director: Affector: Aff 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year) ·mo D63830 September 14 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown, Jeffrey B M.D. 6701 N Charles St. Towson MD 21204 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 19 2006 Registrar

SUPPLIN, ANNO

State of Maryland / Department of Health and Mental Hygiene 2006 29635 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:40 AMM Alice Ellen LeFaivre September 15, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Loch Raven Baltimore Parkville tf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ■ M 2 🔀 F 86 Yrs. 218-07-3637 MD Director 08/06/1920 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. tnside City Limits ul Hygiene. other than "naturel", or Iteme 23s or 28s-f ehow vent, the Medical Exercitar most be profified at 1 ☐ Yes 2 KINO Baltimore Parkville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1808 Yakona Rd USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritat Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Caucasian 3 Nidowed 4 Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker 12 of ser traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be James M McCummings Mary Elizabeth Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages I and 2 s
Department of Health ar
Important: If Item 27 is
eny Injury or ot er trau Kathryn E Henderson/Daughter 1808 Yakona Rd. Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sep 18 2006 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, Maryland Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? en sivy 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturat 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Ellen LeFaivre

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time ol Death Year **Physician** Month Clara A. Lanier September 14,2006 10:35AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Multicare Center Baltimore N/A Months Days Hours Min. Dec. 24, 1923 7. Age (In yrs. last birthday) 82 Yrs. 5. Social Security Number 215–34–7230 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XF Virginia Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show is marked other than "naturel, or items 23s or 28s-f show treumstic event, the Madical Example must be notified at Maryland N/A Baltimore XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W. 40th Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White ۾ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Plant Worker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ice Cream Plant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental P Charles Benjamin Waddey Emsworth Eubank Kent ၉ 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is Charlotte L. Miller Daughter 440 Fawcett Street, Baltimore, Maryland 21211 injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Slale Burial 2 Cremation 3 Removal from State permit. Page Depertment of important: If eny injury or once. Mt. Olivet Cemetery 9/18/2006 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility. Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Lip 21211 23a. Part , Inter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** valths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner andiorascular douce · arteriosderatio thal initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien IF FEMALE Box 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law requires ma litus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autop performed 2 X No 1 Yes 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ InpatienI 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To ð 27. Manner of Death
1 X Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 28b. Time of or Attending Division 5 Pending investigation 1 Yes 2 No death **Director:** filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) Within 2. and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) /6565N. Charles St Suite 2001/Bacto MD 21204 aukner ND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			1 - State Amend item#17,pe	State of Marylan erFH,0859,9/19/06	d / Depa TT <i>Ce</i>	artment of I <i>rtificate of</i>	lealth and Death	Mental Hyg	giene 200	6 29637
B	Physici		1. Decedent's Name (First, Middle, Last	A FFER	MA	N		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	uth	4c. County of Dea	in Court
	Funeral Director		214-01-3023	x 7. Age (In yrs. 30 mg/s) 7. Age (In yrs. 30	last birthday) Yrs.	If Under 1 Year Months Days			9. Bir (, Year) (, 915	thplace (State or Foreign ountry)
	enyland ehow	5	Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the N a or 28a-f be notified	Director	MD BALT  10e. Street and Number  725 MT. WILSON L	IMORE 523	BALIII	10f. Zip Code 2120	18		10g. Citizen of What C	ountry?
9	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28s-f show event, the Modical Examiner must be notified at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of If Yes, specify Cub	Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, Whi	te, etc.
21215-0036	72 hours in natural, of cal Exer	Completed by	3. Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grade)		16a. Dece	1 Yes 2 √ No	pation during most of w	orking	Specify:  16b. Kind of Business	WHITE
2	filed within Hygiene. other than ont, the we		Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	HOME	DO NOT use retire	,	ame (First, Middle,	OWN HO	OME
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	To Be	MEYER	(ma (Print)	Breschl BRESC	HEEIN	LIL	IAN		CHUCHAT
	5 = 7 = Z		19a. Informant's Name/Relationship (7) MYRA FOX / DAUGH 20a. Method of Disposition	TER	13				RE, MD 212	08
Baltimore,	Page: nent o ant: If ury or		1 Donation 5 Other (Specify 21. Signature of Funeral Service License	Removal from State HEBI	REW FR	matory or other pla IENDSHIP  2. Name and Addr	09/	18/2006	BALTIMORE	, MD
Ba	permit. Departr Importa any Inji		Ma.H Levi-			8900 RE	STERSTO	NN ROAD -		E, MD 21208 Approximate
)	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ine cause on each line.	N	CANE	_	ac or respiratory an	1631,	Interval Between Onset and Death
	Examiner	P.	Sequentially list conditions	b. Due to (or as a conseq						
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P.O. Box	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	⊒Ectopic pregnand ☐ Other (specify)	ey .		23d. Date of de Month	olivery Day Year
	w requires thet the by the by should be detact	ě	Part II. Other significant conditions oc	ntributing to death but not res	ulting in the u	underlying cause g	ven in Part I.		obacco use contribute t ∕es 2 ∰No 3 □ P	o the cause of death?
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/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	IIhab				eath (Check only o		
	Jing After fune	tlon: To	27. Manner of Death 1 Avatural 5 Pending	Hospital: 1 ☐ Inpatient 2☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju			dence 6 □Other (Spenow injury occurred	ecity)
Division	of or Attendi after death Director: A d in by the f	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, larm, st y)			28f. Location (S City or Tow	Street and Number or R vn, State)	tural Route Number,
	To the Hospitei or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier (Check only one)  1 Certifying Phyone 2 Medical Example	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the tovestigation, in my	ime, date and plac opinion, death oc	ce, and due to the courred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1 Ke	144	29c. Licen	se number		29d. Date signed (Mon	_
	12		30. Name and address of person who of	completed cause of death (Item	n 23a) (Type	Print)	BA	14, more	e no t	21251
2	Sta Registi		31. Date liled (Month, Day, Year) SEP 1 9	32. Registrar's Signa 2005	iture J.	Sparke	<del></del>	<u> </u>	- 6	

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death Red No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 16, MARY JOSPHINE LYON 2006 6:55 A SEPT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CARROLL WESTMINSTER CARROLL LUTHERAN VILLAGE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F Months 82 Yrs. Director 216-14-6985 MARYLAND /12/1924 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23e or 28e-f show Iter aust be notified at 1XYes 2 No Director CARROLL MD WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 225 FROCK DR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: WHITE γ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 12 should be filed w h and Mental Hygier 7 is marked other ti 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DAVIS NIMROD LENA SHIPLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health ar DESMOND D. LYON -HUSBAND 225 FROCK DR., WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of t ant: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. \* 4 Donation 5 ☐ Other (Specify) ALL COUNTY CREMATION 9/18/06 SYKESVILLE, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Asperatun Preuner /Medical Due to (or as a consequence of) **Examiner** CADIOSUIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of physician and s the burial-transit ann-Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 \ No 1 Yes 1 ☐ Yes 2 **N**O To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a le Funerat I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a, Certifie cal 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) n37a49 and address of person who completed cause of death (Item 23a) (Type, Print) 0 ulu Be Blever 31. Date filed (Month, Day, Year) State 2006 SEP 1 9 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Richard Anthony Lusas

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29b Signature and title of certifier  O.C.M.E.  September 13, 2006  O.C.M.E.  September 13, 2006  Theodore M. King, Jr., MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	/Medical xaminer   wangi   wan	Examiner	faill re. List only one clause on each Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  A UNPENDED  IF FEMALE: 23b Was decedent pregnant in the	Castrointesinal rue to (or as a consequence  AMENDED #23a,27  23c. If yes, outcome of pre	hemorrha of): of): of):  7, perME, g8	age complicating  360, 10/25/06 TT	fatty liver	23d Di	ate of delivery	Between Onset and Death
29b Signature and title of certifier  O.C.M.E.  September 13, 2006  O.C.M.E.  September 13, 2006  Theodore M. King, Jr., MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	/Medical au and transi	sician/Medical Examiner	faill re. List only one clause on each Immedian Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b Was decedent pregnant in the past 12 months?	Castrointesinal rue to (or as a consequence  AMENDED #23a,27  23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of consequence	hemorrha of): of): of):  7, perME, g8	age complicating  360, 10/25/06 TT	fatty liver	23d Di	ate of delivery	Between Onset and Death
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29b Signature and title of certifier  O.C.M.E.  September 13, 2006  O.C.M.E.  September 13, 2006  Theodore M. King, Jr., MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	In of Vital Records, P.O. Box 68760, in Physician: The law requires that the death certificate be executed in Physician: The law requires that the death certificate bas been signed by the attending physician and it fineral director, page 2 should be detached for use as the burial—transit	Certification: To Be Completed by Physician/Medical Examiner	faill re. List only one clause on each Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  A. UNPENDED  IF FEMALE: 23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27 Manner of Death 1 X Naturel 5 Pending Investigatio 3 Suicide 6 Could not be determined	contributing to death but not see a Date of Injury (Month, Day, Year)  Castrointesinal (Specify)  Castrointesinal (Pastrointesinal Pastrointesinal Pastrointes	hemorrha of): of): of): of): of): of): of): of):	age complicating  360, 10/25/06 TT  etal death 3 Ectopic  ther (Specify)  underlying cause given in Pa  26 Place of Death  at 3 DOA Other  Injury 28c Injury at Work  1 Yes 2  eet, factory, office building, e	fatty liver  ic pregnancy  art I  23e. C  1  24a. v  art I  24b. Description  Nursing Home 5  k? 28d. Description  No 28f. Location Town	23d Di Mo Did tobacco use Yes 2 No Vas an iutopsy ierformed? les 2 No Residence ribe how injury of on (Street and I	ate of delivery onth Contribute to a 3 Protect	Death  De
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State 31 Date filed (Month, Day, Year) 32 Pagistrar's Signature	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical Examiner	faill re. List only one clause on each Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  Last  UNPENDED  IF FEMALE:  23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27 Manner of Death  1 X Natural 5 Pending Investigation and Suicide 6 Could not be determined determined  29a. Certifier (Check only one) 2 Medical Examiner:  29b Signature and title of certifier	contributing to death but not solve to (Specify)  and To the best of my knowle on the basis of examination and manner stated.	hemorrha of): of): of): of): of): of): of): of):	age complicating  360, 10/25/06 TT  etal death 3 Ectopic  etal death 3 Ectopic  etal death 3 Ectopic  etal death 3 Ectopic  and Place of Death  at 3 DOA Other,  1 Yes 2  etal factory, office building, e  control of the time, date and place and place and place and place and point on the control of the time, date and place and	fatty liver  art I 23e. C  1 24a. V  1 V  1 (Check only one)  Nursing Home 5  k? 28d. Desc  No 28f. Locate or Town  lace, and due to the courred at the time, and the course the cou	23d Di Mo  Did tobacco use Yes 2 No  Vas an ultopsy lerformed? Yes 2 No  Residence ribe how injury of on (Street and I vn, State)  cause(s) and m date and place, 29d Date	ate of delivery nth	Death  Death  Death  Death  Death  Death  Page 1  Death  Page 2  Death  Page 3  Death  Page 4  Death  Death  Page 4  Death  Death  Page 4  Death
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit of page 2.	Certification: To Be Completed by Physician/Medical Examiner	faill re. List only one clause on each Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  Last  UNPENDED  IF FEMALE: 23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27 Manner of Death  1 X Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  4 Homicide  29a. Certifier (Check only one) 2 Medical Examiner:  29b Signature and title of certifier  80. Name and address of person who can be a series	contributing to death but not specify)  and to be best of my knowled on the basis of examination and manner stated.	hemorrha of): of): of): of): of): of): of): of):	age complicating  3	fatty liver  for pregnancy  art I  23e. C  1  24a. v  28f. Locatron Townson To	23d Di Mo Did tobacco use Yes 2 No Vas an utopsy erformed? es 2 No Residence ribe how injury of on (Street and I vn, State)  cause(s) and m date and place, 29d Date Septer	ate of delivery nth	Death  Death  Death  Death  Death  Death  Page 1  Death  Page 2  Death  Page 3  Death  Page 4  Death  Death  Page 4  Death  Death  Page 4  Death

State of Maryland / Department of Health and Mental Hygiene 200For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Beverly Ann Millet 11:05 PM 11, September 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner N/A Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Year) Nov 30, 1941 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 □ M 2√□ F New York 64 Yrs 220-36-6817 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Parkville Baltimore <u>Maryland</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Itame 23a 3600 Hallmark Court 21234 USA Funerai 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Specify: White Completed by 3 ☐Widowed 4 X Divorced "natural" 16h. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bay - Vanguard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fi f Health and Mental H Item 27 ie marked ot Norman Schneck Madeline Bieber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: if Item 27 is any Injury or other trat once. Shawn A. Millet, Son 9505 Buckhorn Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/16/09 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one callseon each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Or Attending Physician: The law requires that the death certificate be executed that death certificate be executed that death burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the al 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 2 No 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy 2 No 1 Yes 2 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one 20 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Janner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu filled in by the f 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 15, 2006 Kenneth Mitchell McHoul 12:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4411 Hallfield Manor Drive Baltimore Nottingham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 19 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 67 Yrs. 216-36-5531 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Director Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 2 any injury or other traumatic event, the Mudical Example on once. 4411 Hallfield Manor Drive 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Contractor Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Andrew McHoul Bertha Mary Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan McHoul (wife) 4411 Hallfield Manor Dr., Nottingham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 9/19/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Busin 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lina Physician 3 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Certification; To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 5601 Loch Raver charles todaett 32. Registrar's Signature 31. Date filed (Month, Oay, Year) State Registrar

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	/Medic Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of		eptember	18, 201 4c. County of D	
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	e Ma	Director	Maryland Baltimo	re	Middle	e River						1 □Yes 2 XNo
	with th	Dire	10e. Street and Number			10f. Zip	Code			10g.	Citizen of What	Country?
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(0	r item	Funeral	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🛣 No		13. Was Deced If Yes, spec			Puerto Ric	can, etc.)	Black, W	hite, etc.
9	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Examiner must be craffled at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2⊠ No	Specify:			Specify:	White
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7	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+			se retired,	) -				
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Munical Examiner must be notified at Ange.	-	19a. Informant's Name/Relationship (T)	vpe, Print)	198	. Mailing Address	(Street a				ty or Town, State	
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	o the o the omple	Mec	29b. Signature and title of certifier	and manner state	90.	29c	License	number		29d.	Date signed (Mo	onth. Dav. Year)
1	- s + ŏ		) Wahamma	H. Luna	MO	1	Do.	570	61	0	1/181	06
	8		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a)	(Type, Print)		0.		1	1,0/	6 0 0 0
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	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 9 2	32. Régistrar	's Signature	Arn. V.	,					
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			1 - For State Registrar	State of Man	yland / De	partment o	f Health a	nd Men	tal Hygie	ne 2006	29643
			Registrar  1. Decedent's Name (First, Middle, La.	st)		erincate	Dealii	2.0	Reg.	No.	3. Time of Death
	Physicia		Daniel Joseph Mad	ciejewski				g	Month /	Day Year	(:07PM
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Tow	n, or Location of	f Death		4c. County of Deat	ha
				nore HI	SSPITON	Ro.	seda	18		Ba-1+1	MORP
	Funeral			ex	n yrs. last birtho Yr:	Months Da	ys Hours	Min. 8. D	ate of Birth Mo <i>nth</i> , Day, Ye y 17, 19:	ar) 9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	1				Ma	y 1/ <b>,</b> 19.	35 Mar	yland
	how		10a. State 10b. County		Oc. City, Town o	r Location					10d. Inside City Limits
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	death with the Maryland ime 23a or 28a-f ehow r must be notified at	Funeral Director	10e. Street and Number 602 Dunwich Way			10f. Zip Coo	<sup>le</sup> 221		10g.	Cifizen of What Co USA	untry?
	death	era	11. Marifal Status	12. Was Decedent Eve	r in U.S.	13. Was Decedent If Yes, specify (		in? (Specify	Yes or No-	14. Race - Ame	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow ery injury or other traumatic event, the Medical Examinat must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		If Yes, specify ( 1 ☐ Yes 2 🛣		, Puerto Ricar	n, etc.)	Black, White Specify: Wh	•
500	72 hor	Completed by	15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's Usual Oc live kind of work do e. DO NOT use re	cupation	of working	16b	. Kind of Business/	Industry
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Or	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemetery,	sposition (Name of crematory or other Cremator)	place)	Date		Location - City or	
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×	onding use a	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		٥٦٥				23d. Date of deli	very
B	s death	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at tim 9☐ Unknown		3 ☐Ectopic pregna 5 ☐ Other (specify				Month	Day Year
Ρ.Ο	d by t	Phy	9 ☐ Unknown  Part II. Other significant conditions of		ot resulting in th	a underhine cauce	sweep in Part I		23a Did tobacc	n usa cantributa ta	the cause of death?
Division of Vital Records, P.O. Box 68			, and a significant contains to	oranio dang to dodni bujin	or rosoning ar a	a dilderlying cause	given in Paiti.		,		obably 4 Unknown
Sor	w req	lete							24a. Was an	24b. Were au	fopsy findings available
Re	icien: The lav certificate has rector, page 2	Completed						_	autopsy performed Yes	? death?	fopsy findings available completion of cause of
ital	artifice ctor, p	Bec	25. Was case referred to medical examiner?				26. Place	of Death (Che			20110
of V	Physic this c	2	1 ☐ Yes 2 No		2 ER/Outpa	Illent 32 DOA				6 ☐ Other (Spec	cify)
uo	ding h. After funer	tlon	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Tirr		njuryat Work? I∐Yes 2∐N		Describe how in	njury occurred	
<u>visi</u>	Atten r deat ector: by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm			28f. L	ocation (Street	and Number or Ru	ral Route Number,
ā	ital or rs afte rel Dir led in	Cert		building, etc. (S					City or Town, St		
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier / Certifying Ph (Check only 2   Medical Exam	ysician: To the best of miner: On the basis of exand manner stated	amination and/o	eath occurred at the investigation, in r	e time, date and ny opinion, death	place, and d h occurred at	ue to the cause the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	and mariner stated		29c. Lic	ense number		29d.	Date signed (Month	i, Day, Year)
	- S P O		11-1		M	> 1	5341	62	9	-17-(	
	7		30. Name and address of person who	completed cause of death	h (Item 23a) (Ty	pę, Print)		000			e, MD2/23
	\		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	in squ	ral e	DIIV	re Ba	Itimor	£ , MU2123
	Sta Registr	_		2006	a de	Goode					

			1 - State of Marylan		artment of H rtificate of L			giene 200	5 29644
	Physici	an	Decedent's Name (First, Middle, Last)     Calvin Edward	Marra	rd		2. Date of Dea Month SEPT	th Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	Mayna	4b. City, Town, or	Location of Death	1	4c. County of De	
	LAGIIII	iei	Esthers Place		Balt	imore C	ity	N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1) 1 2 15-22-6016 1 2 M 2 日 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug • 12	, Year)	irthplace (State or Foreign Country)  aryland
	DO .		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	, Town or Lo	cation				10d. Inside City Limits
	shored at	ក	Maryland Baltimore	, 10 411 01 20	Cation	Dundal	ζ		1 ☐ Yes XXNo
	the A	Director	10e. Street and Number		10f. Zip Code			0g. Citizen of What	Country?
	3a or		822 Oakleigh Beach Road			21222		United St	
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.	S. 13. \	Was Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Race - Ar	nerican Indian,
ဖွ	after or Ite	E	Armed Forces?  1 □ Never Married 2√2 Married 1√2 Yes Give		f Yes, specify Cubar 1 ☐ Yes 2 No	n, mexican, Puert  Specify:	o Hican, etc.)	Black, Wi	nite, etc.
93	urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: ₩₩፲፲					W	hite
4	n 72 l	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupa kind of work done d DO NOT use retired	ation <i>furing m</i> ost of wor	king	16b. Kind of Busines	s/Industry
5.	withi iene. then	d Lo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Years		eelworker			Steel I	ndustry
2	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)		CCIWOIRCE		ne (First, Middle,		
<u>a</u>	uld be Aenta rked tic ev	To B	George E. Maynard			Lola N	4. Shirk		
Maryland 21215-0036	and N ls ma		19a. Informant's Name/Relationship (Type, Print) (Daughter						
	and and mast		Mrs. Claudia Bruzdzinski		Oakleigh	Beach Ro		dalk, Mary	
altimore,	ges 1 t of H If ites or oth		20a. Method of Disposition  20b. P Burial 2 ☐ Cremation 3 ☐ Removal from State	ace of Dispo: metery, crem	sition (Name of matory or other place			20c. Location - City	
Ę.	t. Pag tmen tent:				Mem. Gdns		5/2006	Bel Air,	Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumetic event. If a Marical Examination of items 20 once.		21. Signatur Funeral Service Licensee	Du	7922 Wise	Funeral I Ave. D	undalk,	Oundalk, I Maryland	nc. 21222
			23a. Part1. Enter the disease or complications that caused the death shock, or heart felies. List only one cause on each line.	. Do not ente	er the mode of dying	g, such as cardiad	or respiratory arr	est,	Approximate Interval Between
	Fnysician		disease of condition	redia	e Int	farctio	N		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of the control of		مادده	1			7 11 50
		<u>-</u>	Sequentially list conditions	ence of it	) grade	cry a	(Sease		2 913
21.	uted 1 ansit	Examiner	Cause (Disease or injury that initiated events						10 452
One.	licate be executed physician and s the burial-transit	Еха	resulting in death) Last  Due to (or as a consequence of the consequen						J
202	ute be nysicia ne bur	dicai	d						
ص ص	artifica ing ph e as ti	Med	IF FEMALE:						1
S S S S	leath certific attending p	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal	death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
7 V P.O. 1	he de the a	ysic	1  Yes No 9 Unknown	ath 5∟	Other (specify)				
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Ph	Part II. Other significant conditions contributing to death but not resu	Ilting in the ur	nderlying cause give	en in Part I.			to the cause of death?
入人 Records,	w requir been si should	Completed		,	mente	7	1	es 2 □No 3 □	Probably 4 Unknown
Z Sec	elaw hasb je 2 sl	nple	depression, hypert	ensi	sn.		24a. Was a autops	y prior to	autopsy findings available completion of cause of
	icate						perform 1 ☐ Yes	ned2 death′ No 1 □ Ye	
Vital	ysicien: The law is certificate has b director, page 2 s	o Be	25. Was case referred to medical examiner?  1   Yes 2   W No   Hospital: 1   Innatient 2		Othe	NET.	th (Check only on		Accept
> 5	Physic this stal di	<b> -</b>	27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injury	at at	ome 5 Reside	ence 6 XOther (Sp ow injury occurred	becity) ASSISTED
7 00	nding Ph th. : After th s funeral	atior	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Work	(? Yes 2 ☐ No			Facility.
CAL	Attence at death ector: by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or	Rural Route Number,
	tel or rs afte el Dir ed in	Certification:	Dullding, etc. (Specif)				City of 10wi	r, State)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, t	edicai	29a. Certifier (Check only one)  Certifying Physician. To the best of my known one)  Medical Examiner: On the basis of examinal and manner stated.	wiedge, death ion and/or inv	roccurred at the tim vestigation, in my op	ie, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
			Master I week	0	DY	1575	7	Sept 1	3, 2006
	10H		30. Name and address of person who completed cause of death (Item Matthew McNashe	7 4	Print)	estera	1 Ava	2 30	It, MD
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signa \$\frac{1}{2}\$	Mre A	porte			7	21224

			1 - For State of Maryland / Der Registrar	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2006 29645
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Sara Mish Medford	2. Date of Death Month Day Year SEDIEMDES 15 2000 0810 A M
	Examir		4a. Facility Name (If not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Death Baltimore  4c. County of Death N/A
	Funeral Director		5. Social Security Number 220–14–9089 6. Sex 1 □ M 2 ▼ F 97 Yrs.	Months Days Hours Min T (Month Day Year) O Country 1 1
	anyland •how	or	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or  MD  Baltimore	Location 10d. Inside City Limits Catonsville 1 □ Yes 2 No
	with the M a or 28a-f	Directo	MD Baltimore  100. Street and Number  709 Maiden Choice Lane Apt. RGT-213	10f. Zip Code 10g. Citizen of What Country?
36	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23e or 28e-f ehow ha Madical Exeminar must be notilied at	by Funeral Director	-	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes 2 No Specify:  1 Yes 2 No Specify:  1 Yes 2 No Specify:
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hygiane. Id other than "naturel; or Iteme 23a or 28a-f e how event, the Madical Examinational tendilised at	Completed I	15. Decedent's Education (Specify only highest grade completed)  [Given tary/Secondary (0-12)   College (1-4or 5+)   Iffe	cedent's Usual Occupation live kind of work done during most of working b. DO NOT use retired)  Librarian  Anne Arundel County
land 2	2 should be filed v n and Mental Hygie is marked other reumatic event, in	To Be C	17. Father's Name (First, Middle, Last) Frank Winder Mish	18. Mother's Name (First, Middle, Maiden Sumame) Eleanor Dubbs
, Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other treumatic: anges.		19a. Informant's Name/Relationship (Type, Print) Eleanor M. Heldrich - Daughter 21 0	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oakridge Court, Lutherville, MD 21093
more	Pages 1 ment of He ant: If iten ury or oth		Burial 2X Cremation 3 Removal from State West Hold	position (Name of Date 20c. Location - City or Town, State 20c. Lo
Balt	Department Department Important: any Injury o		21 Signature of Funeral Service Licensee	<sup>22. Name and Address of Facility</sup> Ambrose Funeral Home, Inc. 328 Sulphur Spring Rd., Arbutus, MD 21227
	death certificate be executed  Exam  We eltending physicien and death certificate as the burial-transit	dicai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  Conset and Death  Conset and Death
.O. Box 6	at the death certifice by the ettending pl tached for use as t	Physician/Me		3 DEctopic pregnancy 23d. Date of delivery Month Day Year
rds, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 10 3 Probably 4 Unknown
Vital Records,	The law ete has b page 2 s	e Completed	25. Was case referred to medical	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
Division of Vi	Attending Physician: Ir death. Octor: After this certific by the funeral director.	Certification; To B	examiner?  1	of 28c. Injury at 28d. Describe how injury occurred
=	2 4 4 2	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	City or Town, State)
	To the Hospital of within 24 hours at To the Funeral Disombletely filled is	Medical	(Creek only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
2	J. T. D.	_	30. Name and address of person who completed cause of death (Item 28a) (Type	29c. License number  29d. Date signed (Month, Pay, Year)
0	1		30. Name and address of person who completed cause of death (Item 28a) (Typ.  31. Date filed (Month, Day, Year)  32. Megistrar's Signature	iten dure Can Catensille
	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	barle

			1 - State of Maryland / Department of Certificate o	Health and M f Death	lental Hygi	ene g. No. 2006	29646
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	1	3. Time of Death
	Physici /Medio		EDWARD Mick		September	Day Year	6:15 PM
3	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town	, or Location of Death		4c. County of Dea	th
			UNIVERSITY OF MANYLAND MODICAL (EXTEN BALL	MURE			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes		8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
L	Director		219-32-6190 70 Yrs.		08/31/19	936	MD
	pue *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Aaryli eho	5					1 ☐ Yes 2 ☒ No
	28a-	ect	MD Anne Arundel Linthicum  10e. Street and Number 10f. Zip Code		10	g. Citizen of What Co	ountry?
	filed within 72 hours after death with the Maryland Hygiene. sthar then "naturel", or Items 23a or 28a-f ehow ent, the Medical Examination must be notified at	by Funeral Director	518 Koch Road 2109			U.S.A.	outiny.
	leath	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	f Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian.
(0	ifter o	Fun	Armed Forces? If Yes, specify Ci	uban, Mexican, Puerto I	Rican, etc.)	Black, Whit	e, etc.
ဗ္ဗ	ours a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	lo Specify:		Specify: Wh	iite
21215-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occ (Specify only highest grade completed) (Give kind of work dor	upation ne during most of working	1	6b. Kind of Business	/Industry
2	ithin i	npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use reti	red)	ng		
2	ygier ygier than th	ပ္ပ				Machines	
Maryland	be fill H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
충	should be ind Mental I smarked or umatic eve	은	Joseph Simon Mick		la Bennan		
Nai	h and h and 7 is n	8	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Stre</i>				Zip Code)
	1 and Healt em 2		Mrs. Marguerite Mick / wife 518 Koch Ro  20a. Method of Disposition (Name of			2 1090 Oc. Location - City or	Town State
٥	ages if it	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examiner must be notified at 90ce.		4 Donation 5 Other (Specify) Glen Haven Mem. I			Glen Burn	
Ba	Dermi Depa Impo eny i			fress of Facility Sir Ave SW; G]	_		
	_		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d				Approximate
,	<b>D</b>		shock, or heart failure. List only one cause on each line.	,,	,		Interval Between Onset and Death
Ý	Physician /Medical	-	disease or condition resulting in death)  a. AOUTIC DISSECTED  Due to (or as a consequence of):				
	Examiner		Due to (or as a consequence of).				
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	outed Id	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Ó	en ar	EX	resulting in death) Last Due to (or as a consequence of):				
8760,	ficate be executed physicien and s the burial-transit	dicai	d				
W	ng pt	Med	IF FEMALE:				
Вох	death certific e attending p od for use as	an/l	23b. Was decedent pregnant in the past 12 months?	ncv		23d. Date of del	
	0 00 0	sici	1 Yes 2 No 9 Unknown 5 Other (specify)			Month	Day Year
P.0	thet the death	Physician/Me			- and the second		
ŝ	ര് ഉദ്	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		acco use contribute to	obably 4 <b>M</b> Unknown
Record	w requir been si should	Completed			1 103	2010 3011	obably 4 220 IKIOWII
Şeç	The law ate has t page 2 s	Ę.			24a. Was an autopsy	prior to	topsy findings available completion of cause of
7					perform 1 ☐ Yes 21		2 <b>2</b> No
Vital	ding Physiclan. n. After this certific funeral director	Be	25. Was case referred to medical examiner?  1. Type 2. Chapter Hospital: Hospital:	26. Place of Death			
5	Physithis raldii	- To	1 Enpatient 2 EN/Outpatient 3 DOA	4 🗆 Nursing Hon	ne 5 Residen 28d. Describe how	nce 6 Other (Spe	cify)
0	ding P. After fune	tion	1 Natural 5 Pending (Month, Day Year) Injury W	ork? □Yes 2□No	ed. Describe nov	v injury occurred	
Division	Attending r death. actor: After by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office		28f. Location (Stre	eet and Number or Ru	ıral Route Number
Š	Hospital or Attend 24 hours after death Funsral Director: itely filled in by the	Certification:	4 Homicide building, etc. (Specify)		City or Town,		and riodio riomor,
	Hoepital or 24 hours afte Funsral Dir tely filled in I		29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowledge, death occurred at the	time, date and place, a	and due to the cau	use(s) and manner as	stated.
	To the Hoepital or Attenwihin 24 hours after death within 24 hours after death To the Funsral Director: completely filled in by the	edicai	(Check only 2   Modical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	To the I within 2 To the I complet	Ž	29b. Signature and title of certifier 29c. Lice	nse number	290	d. Date signed (Monti	h, Day, Year)
	-4		D	64003	5	SEPTEURIN	15 2006
	10		Name and address of person who completed cause of death (Item 23a) (Type, Print)	-			
			31. Date filed (Month, Day, Year) 32 Aegistrar's Signature	meet Na	1204	BACTMENE	MD 21201
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 9 2006 SEP 1 9 2006 SEP 1 9 2006				

State of Maryland / Department of Health and Mental Hygiene  $2\,0\,0\,6$ 29647 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year HESTER VIRGINIA MEKINS **SEPT** 14 2006 6:58 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6921 BEECH AVE. BALTIMORE **BALTIMORE** 7. Age (In yrs. last birthday, If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ F Hours Director 218.46.5514 62 JULY 11, 1944 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits , or itema 23e or 28a-f show hiver must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 2603 YORKWAY RD, APT. B 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give**XX** Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify the Medical Exer þ 3 🗌 Widowed XX Divorced naturei', WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **WAITRESS** RESTAURANT other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other traumatic event spice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANCIS WILLIAM BEALE HESTER PEARL PIERCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6921 BEECH AVE. BALTIMORE, MD 21206 DAUGHTER BONNIE WADDELL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 200 Cremation 300 Removal from State 4 □ Donation 5 □ Other (Specify) TUCSON, FUNERAL HONE 9.14.2006 TUCSON, AZ 21. Signa re of Filneral Service License 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 CREGORY FIN M01148 Part1. Enter the disease, of comshock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between one dause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Stage Cardis my spath /Medical Due to (or as a consequence of): Examiner Due to for as a consequence of): Celho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Breant cancer Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 🗷 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes is after deam.
Ital Director: After this cerum.
Ital by the funeral director, p. 2**XX**No Be 25. Was case referred to medical 26. Place of Death (Check only one) DAUGHTER/CAREGIVER 1 ☐ Yes 2XX No Hospital: Other: 4 Nursing Home 5 Residence ome 5 Residence 6 Other (Specify) RESIDENCE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050566 SEPTEMBER 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 SAMER S. NAJJAR, <u>MD JOHN HOPKINS BAYVIEW M</u>EDICAL CENTER 4940 EASTERN AVE. A-1 EAST BALT., MD 21224 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State Registrar

		•	For State Registrar	State of Maryland	•	rtment of F		-	giene Rag. No.	2006	29648
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
ı	Physici		James Patrick Man	ning, Jr.				Septem	ber	15 2006	7:31pm
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number) HOSPITAL	,	4b. City, Town, o	Location of Dea		4c.	County of Death	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y. Year)	Cour	olace (State or Foreign otry) nsylvania
	70		Usual Residence of Decedent	100 00	. T1					1,	04 1-14 03-11-3-
	arylar show	_	10a. State 10b. County		, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 21 No
	8a-f	cto	Maryland Baltimore	Cat	tonsvi						
	with th	Dir	10e. Street and Number			10f. Zip Code			_	zen of What Cour	ntry ?
	s 23g	rai	1905 Branston Road	2. Was Decedent Ever in U.	C 12 V	21228	lianania Origina /	Coopin Vac or No	USA	14. Race - Americ	nan Indian
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene.  marked other than "natural", or itsms 23a or 28a-f show imatic event, the Mudical Examinations and the notified at	by Funeral Director	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates:	lt.	Vas Decedent of H Yes, specify Cuba ☐ Yes 2☑ No	Specify:	rto Rican, etc.)	)*	Black, White,	
ŏ	2 hou	pa	15. Decedent's Educa		16a. Deced	ent's Usual Occup	ation		16b. Ki	nd of Business/In	dustry
75	nin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of work done OO NOT use retired	during most of wo d)	orking			
2	d with	E	Elementary/Secondary (0-12)	4	Labo	rer			Coı	nstructi	on
Maryland 21215-0036	ould be filed v Mental Hygie varked other t vatic svent, the	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	ime (First, Middle	Maiden	Sumame)	
<u> </u>	Aents Aents rked	To	James P. Manning,	Sr.			Jean Pl	hyllis S	hreve	e	
a	es 1 and 2 should b of Health and Ments fitem 27 is marked r other traumatic s		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street	and Number or F	Rural Route Numb	er, City o	r Town, State, Zip	Code)
	and and a salth	١.	James P. Manning, S			Branston	Road;				
altimore,	of He fiten		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ Re	moval from State	emetery, cren	sition (Name of natory or other plac	(e)	Date		cation - City or To	
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specify)	Net	w Cath		1	0/2006			•
Balt	permit. Pages Department of the important: If its sny injury or of once.		21. Signature of Funeral Service Limser	ds	22	Name and Addre Funeral 1630 Edn	Home of	Catonsv	ille,	Inc.	MD 21228
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one		n. Do not ente						Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	Esophage	eal c	ANCel	_			4	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ							Ofminore
	Examiner		Sequentially list conditions, b.								
7	IP =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	зепсе от).						
1	rans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last								
ő	e exe		resulting in death) Last	Due to (or as a consequ	ience of):						
8760,	cate be executed physicien and the burial-transit	dicai	d.								
9 ×	Attending Physicien: The law requires that the death certificate be executed it death.  ector: After this cartificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE:	c. If yes, outcome of pregna	DOV						
Bo	that the death certificated by the attanding posterior detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		1 2	23d. Date of delive Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	9d(II 5 _	Cirier (specify)					
م.	that the	モ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	obacco u	se contribute to the	ne cause of death?
ds,	w requires that been signed to should be det	d b	None-	-				10	Yes 2[	□No 3□Prob	ably 4 Dnknown
ö	v requ	ete						24a. Was	20	24h Were auto	ney findings available
Be e	has ge 2	Ę						auto	psy ormed?	death?	psy findings available mpletion of cause of
ā	icisn: Th cartificate rector, pag	ပို	25. Was case referred to medical				GC Diago of Do	1 ☐ Yes	2 No	1 🗆 Yes	20040
5	s cart	To B	avaminar?	spital: 1 ☐ Inpatient 2 V	ER/Outpatien	Oth	or.	Home 5□Resi		S Cother (Specif	w1
ō	Physer this eral di		27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe			//
<u></u>	nding uth. r: Afte	at o	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		K? Yes 2∐No				
Division of Vital Records, P.O. Box	or Atternation of the control of the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location ( City or To		d Number or Rura )	I Route Number,
	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this cartificate his completely filled in by the funeral director, page	edicai C		cian: To the best of my kno er: On the basis of examinal and manner stated.							
	ro thi vithin ro thi	¥.	29b. Signature and title of certifier			29c. Licens				e signed (Month,	
}	C > F 0		) Snock 1 D	hysic: And	,	Dog	7747	8	Sep	tembe	R 15.2006
	0		30. Name address of person who cor	npleted cause of death (Item	1 23a) (Type,	Print)	2 ()3	U	-4		
	3 Sta	te.		le JR (M)		Caton	Aven	ue Ba	riti,	noze, Mo	R 15,2006
1	Regist		SEP 1 9 200		1 60	ech					

DHMH 17 Rev 1/2001

MANNING, JAMES

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

9 2006

		-	For State Registrar	State of Ma	ırylan		artmen <i>tificati</i>			d Men		ene 3. No. 2 (	006	29650
	ysicia		1. Decedent's Name (First, Middle, Las Barbara	st)				M	ore		Date of Death Month Eptember	Day	Yeer 2006	3. Time of Death
	Medic amin		4a. Facility Name (If not institution, give The Johns Hopk	. 11	al			Town, or	Location of D	Death	Cp (Fill doc)		ty of Death	
Fun Dire	eral		5. Social Security Number 6. S 238–72–9320			ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. D	Date of Birth Month, Day, 1 2-27-1	(94) 943	9. Birthp Cour Nort	olace (State or Foreign on Carolina
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itema 23e or 28e-f ahow	confibran	ctor	Usuel Residence of Decedent  10a. State 10b. County  N. C. Pasquota  10e. Street and Number	ank		zabeth		Code			10	g. Citizen of	1 What Cour	0d. Inside City Limits 1
er death wil	diamora	œ l	202 Summerfield St	12. Was Decedent E Armed Forces?		S. 13. V	279 Vas Deced Yes, spec	dent of His	spanic Origin n, Mexican, P	? (Specify Puerto Rica	Yes or No-		• ace - Americack, White,	
-0036 Phours after Stural', or I	sal Exami	ed by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	16a. Deced	I □ Yes	ι .	Specify:		11		Business/Inc	
Baltimore, Maryland 21215-0036  semit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene.  mportant: If Itam 27 Ia marked other than "natural", or	The Madis	Completed by	(Specify only highest gra		+)	(Give	kind of wo DO NOT us	rk done d	uring most of	f working		Disab		
aryland should be file and Mental Hy.	allc avent	To Be C	17. Father's Name (First, Middle, Last) Winford Glenn St						18. Mother's Rosett		st, Middle, Ma nton	iden Suma	ime)	
ore, Mar	ner traum		19a. Informant's Name/Relationship ( Marie Stokley	Type, Print)	- Inc	330	7 Fie	ldvi	ew Roa	d Gw	ute Number, ( ynn Oa	k,Mar	yland	21207
timore Pages 1 tment of H	jury or oth		20a. Method of Disposition  1 ⊠ Surial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	()	C	lace of Dispo- emetery, crem	ratory or o Fores	ther place t	09	Date 1-25-2	2006 Ow	ings	· City or To	, Md
Balti permit. Departr	any in		21. Signature of Funeral Service Licer			7	00 S.	Bee	chfiel	d Ave		more,		land 21229
Physic /Med Exam	ical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequ	Failu uence of):	re			rdiac or res	spiratory arres	.t,	•	Approximate Interval Between Onset and Death
- , F	ial-transit	Exal	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequ	zence of):	wt-	Can	ler					15 days
I Records, P.O. Box 687 The law requires that the death certificate ate hes been signed by the ettending phys	8	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the composition of the comp	2 🗆 Fetal	death 3	Ectopic pr			1155			ate of delive	ory Day Year
ords, Poquires that en signed t	pe	٦	Part II. Other significant conditions o	ontributing to death bu	it not resu	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did toba 1 ☐ Yes	./	ntribute to th	ne cause of death?
Vital Reccidation: The law recentificate hes be	C)	Completed								_	24a. Was an autopsy performe 1 Yes 2		. Were auto prior to cor death? 1 D Yes	psy findings available impletion of cause of 2 No
Phys this	la G	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 00  27. Manner of Death  1  Satural 5  Pending investigation	Hospital: Langaties  28a. Date of Injur (Month, Day	y T	ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4 ☐ Nursir	ng Home 28d.	5 Residen			v)
Division of the normal setter deat in Diractor:	ad in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At ho . (Specify	ome, farm, stre	et, factory	y, office			Location (Stre City or Town,		nber or Rura	l Route Number,
To the Hospitel within 24 hours e	completely filled in by the funer	Medical	29a. Certifier 10 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examinal	wledge, death tion and/or inv	occurred estigation	at the tim , in my op	e, date and p inion, death o	place, and o occurred a	due to the cau t the time, dat	se(s) and me and place	nanner as st	ated. the cause(s)
To t within	Com	2	29b. Signature and title of certifier  Emily Sign	lnoz, Medi	cal	Doctor		RES	number -000			_	ed (Month,	Day, Year) 5, 2000
	7		30. Name and address of person who Enily Sychnor, The	Junns Ho	pkins	Hospit		00 Na	4h Wolf	25tree	r, Balt	more	Mary	1 and 21214
Re	Sta egistra	-	31. Date filed (Month, Day, Year) SEP 1 9 2006	32. Registra			ر:							

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State	of Maryla	ind / Depa <i>Cei</i>	artment of rtificate of	Health and I	Mental Hyg	giene Reg. No. 20	06	29651
	Physicia	an	Decedent's Name (First, Middle, L			VI 001			2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al -	GEORGE  4a. Facility Name (If not institution, g	R.		NICOL	4h City Town	or Location of Deat	SEPT.	17 4c. County	2006 of Death	2:45 p M
	Examin	er	511 MAIN STREET #11		3.11.20.7			UREL				AMERICA
	Funeral			Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days			h Year)	9. Birthpla Count	ace (State or Foreign
	Director		215-38-4637	1 🔀 M 2 🗆 F	65	Yrs.			NOV. 18,	1940	MARYL	
	land w		Usual Residence of Decedent  10a. State  10b. County		10c.	City, Town or Lo	cation				10	Od. Inside City Limits
	Mary -1 eh	ţō	MARYLAND PRINCE G	FORGES	L	AUREL						1,□Yes 2□No
	n 28a	Director	10e. Sireet and Number				10f. Zip Code			10g. Citizen of V	What Count	iry?
	23a c		511 MAIN STREET #11	8			2070			UNITED ST		
980	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28s-f show sayl injury or other traumatic event, the Medical Examinar must be notified a page.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed F	2X□ No live		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🗓 No	Hispanic Origin? (S ban, Mexican, Puen o Specify:	Specify Yes or No- to Rican, etc.)	Specify	e - America ck, White, e /: WHIT	etc.
Q N	72 ho	eted	15. Decedent's (Specify only highest of	Education	)	(Give		during most of wo	rking	16b. Kind of Bu	usiness/Ind	lustry
21215-003	hen "	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retir DR I VER	ed)		CONSTRU	ICTION	
	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, La	st)		moon	DICTACIO	18. Mother's Na	me (First, Middle,			
an	lid be ked o	To Be	ALEXANDER NICOL					THELMA ED	WARDS			
Maryland	and N		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Stree	at and Number or Ri	ural Route Numbe	r, City or Town,	State, Zip	Code)
	and 2 eaith m 27 i		WILLIAM NICOL/BROTHE	R	loo		LEEPY HOLL	OW ROAD FA	LLS CHURCH			Class
Baltimore,	ges 1 st of H st ite or otl		20a. Method of Disposition 1 Deurial 2 Coremation 3		n State		matory`or other pl	1	Date	20c. Location -		
=======================================	iit. Pe intmer intent njury		4 □ Donation 5 □ Other (Spe 21. Signature of Fuheral Service Lice		M	ETRO CREM	AIORY 2. Name <i>a</i> nd Addi	9/19/	2006	CATONSVIL	.LE, MA	KYLAND
Ba	Depre impo		Nam {	- h.	Mr-	FL	ECK FUNERA	L HOME 7601			LAUREL	MD 20707
,8760,	Physician be executed /Medical Examiner but and street before the putial-transit	dical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	o (r s a cons	sequence of):	btuch Luz	uffici or pulv diseas	undy	y bise	est!	Interval Between Onset and De th
.O. Box 6	The law requires that the death centificate ate hes been signed by the attending phypage 2 should be detached for use as the	by Physician/Medic	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pre birth 2 F gnant at time on	etal death 3	□Ectopic pregnan □ Other (specify)	су			te of delive	ry Day Year
۵.	ss that gned b	by Pi	Part II. Other significant condition	s contributing to	death but not	resulting in the u	inderlying cause g	iven in Part I.	1			e cause of death?
Vital Records,	w require been si should I		Beheme C	archie	mya	puth	7		120	(es 2□No	3   Probi	ably 4 □Unknown
3ec	elaw hesb je2st	Completed	ACDM	, ,	weren	unland	centi	Hane	24a. Was autop	osy i	Were autor prior to con death?	psy findings available inpletion of cause of
a	n: Th ficate or. pag		25. Was case referred to medical	Mul	ema			00 Blace of De	1 ☐ Yes	> No	1 🗌 Yes	2∕∆ No
څ	/sicia s certi directo	To Be	examiner?	Hospital:	Inpatient 2	P ☐ ER/Outpatie	nt 3 DOA	ther: 4 Nursing I	Home 5 Resid	dence 6 ⊡Oth	ner (Specifi	()
n of	ng Phy Iter thi neral o		27. Manner of Dealh 1 Natural 5 ☐ Pending	28a. Dat	e of Injury onth, Day Yea	28b. Time o				now injury occur		, , , , , , , , , , , , , , , , , , , ,
Sio	tendir leath. tor: A the fu	catio	2 Accident investiga 3 Suicide 6 Could no	the -		la la		Tes 2 No	004 1	24	5	10
Division of	s efter of bit Directed in by	Certification;	4 Homicide determin	ad 208. Fla	ce of Injury - A Iding, etc. (Sp.	il home, tarm, st ecify)	reet, factory, offic	8	City or Tox		ier or mura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	edicai (		caminer: On the				time, date and plac opinion, death occ				
	To the I	Me	29b. Signature and title of certifier	0	4		29c. Lice	nse number		29d. Date signe		
)	T		Marie	UD	Jan /		107	9923		SEPTEMBER	c 19, 2	1006
Í	0		11/2 1	ho completed ca		Item 23a) (Type, 50 VAN DU		LAUREL MAF	RYLAND 207	707		
	Str	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Si		hasks	LAUREL PIA	., ., ., ., ., ., ., ., ., ., ., ., ., .			
	Regist		SFP 19	2006	The same	10 M	The same					

		1 - For State Registrar	State of	of Marylan	id / Depa <i>Cer</i>	rtment <i>tificate</i>	of Hea	Ith and N ath	Mental Hy	giene, Reg. No.	2006	29652
		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea	ath Day	Year	3. Time of Death
Physic /Med		JUANITA	Α.			0	1.Pha	0+	SEPTENBER		2006	1234 PM
Exam		4a. Facility Name (If not institution, ga				4b. City, T	own, or Loc	ation of Death		4c. C	county of Deat	h
		JUHNS HOPKINS BAY					TINDE					
Funera		,	Sex 1 □ M 2 🔀 F	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Birt (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
Directo	r	213-62-2550 Usuel Residence of Decedent	_ 71	30	113.				10-24-	-194	/ Ba	ltimore, MD
land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Mary -fah	ţō	MD n/a		В	altimo	ore						1 XYes 2 ☐ No
r 28a	Irec	10e. Street and Number				10f. Zip (	Code			10g. Citiz	en of What Co	ountry?
death with the Maryland ms 23a or 28a-f ahow rroust be notified at	0	3912 Mt. Ple	asant .	Avenue				212	24		USA	
deat	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \	Was Decede	nt of Hispar	nic Origin? (Se	pecify Yes or No o Rican, etc.)	- 1	4. Race - Ame Black, Whit	
or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes If Yes, Gi	2 No		1 ☐ Yes 2	_	pecify:			Specify: Wi	•
hours a	d by	3 Widowed 4 Divorced	Year or E	Dates:								
- 72 nat	Completed	15. Decedent's l (Specify only highest g			(Give	ient's Usuai kind of work DO NOT use	Occupation done during retired)	g most of wor	king		d of Business	
withii	E G	Elementary/Secondary (0-12)	College (	1-4or 5+)		erato	,			Goe	tz's (	Candy
Hyginathar.		10th 17. Father's Name (First, Middle, Las	t)		Оре	ELACC		Mother's Nan	ne (First, Middle,	Maiden S	Sumame)	
ME, MALYICALICALIDEDUCO Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural" or Items 23a or 28a-f show other traumatic avent, the Macinal Examination and illed at	To Be	Andrew Louis R	avman					Mav	Okel			
shound M	-	19a. Informant's Name/Relationship		Spouse	19b. Mailir	g Address	Street and I	Number or Ru	ral Route Numbe	er, City or	Town, State, 2	Zip Code)
ING 2 and 2 27 io		Joseph C. Olip	hant J	r.	3912	Mt.	Plea	sant i	Ave, Bal	Ltimo	ore MI	21224
of He		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Name	e of ner place)	ì	Date		ation - City or	
altimo		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Oa	klawn	ı		9/20	/2006	Balt	imore	, MD
Darril. Pages Department of P Important: If ite any injury or of	3	21. Signature of Funeral Service Lic			22	. Name and	Address of	Facility Jos	seph N.	Zaı	nnino	Jr. FH
D WOEE 8	S .	Maria 4.	. /  -	nnix	2	63 S.	Con	kling	St. Ba	altin		MD 21224
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplications that y one cause on	caused the deat each line.	th. Do not ent	er the mode	of dying, su	uch as cardiad	or respiratory a	rrest,	:	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	a Preu	AIROM.								3 4448
/Medica Examine		resulting in death)	Due to	(or as a consec	quence of):							•
		Sequentially list conditions,	b. Sme	(or as a conseq	ung cance	R						lyeag
Tied Tied	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	54610	(01 43 4 0011300	judito dij.							
xecu n and al-tra	xar	that initiated events resulting in death) Last	c	(or as a consec	quence of):							
6 eattanding physician and dor use as the burial-transit	dical		© d									
ificate g phy as the	edlo		V									
cords, P.C. BOX or requires that the death certific been signed by the attending phound be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Testania ara	~~~~			23	3d. Date of de	•
death death death	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at time of o		]Ectopic pre ] Other (spe					Month	Day Year
BCOrds, F.C. law requires that the as been signed by the 2 should be detached.	hys	9 Unknown	9∐ Unkr	10WN								
S, sethan	by	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying ca	use given in	Part I.				the cause of death?
cord  * requir  been si should									1	Yes 2□	]No 3∐Pi	robably 4 🗹 Unknown
	Completed								24a. Was autor	osv	prior to	utopsy findings available completion of cause of
_ ⊨ age	Son								perfo 1 ☐ Yes	rmed? 2 No	death? 1 🗌 Yes	2 □ No
OT VITAL HER Physician: The lav this certificate has ral director, pege 2	Be	25. Was case referred to medical examiner?	I la aniant.	,			•	. Place of Dea	ath (Check only o	on <i>e)</i>		
dis X	မ	1 Yes 2 No			ER/Outpatier			4 ☐ Nursing H	lome 5 Resi			cify)
SING F	lo iii	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	M	Work?	2 🗆 No	28d. Describe	now injury	occurred	
UIVISION If or Attending after death. Director: Afte	cat	2 Accident investigat 3 Suicide 6 Could not	be 200 Place	e of Injury - At h	ome farm str			2   140	28f Location /	Street and	Number or R	ural Route Number,
Olv after Direct	Certification:	4 Homicide determine		ding, etc. (Speci		eot, ractory,	Onice		City or To		770111007 07 71	arai riggio repirigor,
UIVISION OI To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	2	29a. Certifier 1 Certifying	hysician: To th	e best of my kno	owledge, deat	h occurred a	it the time, o	date and place	, and due to the	cause(s) a	and manner as	s stated.
Ho. 24 h Fur letely	edical	(Check only 2 Medical Exone)	aminer: On the l	basis of examination	ation and/or in	vestigation,	in my opinio	on, death occu	rred at the time,	date and	place, and due	e to the cause(s)
To th Within To th	S S	29b. Signature and title of certifier				29c.	License nu	mber		29d. Date	signed (Mont	h, Day, Year)
		Suklu				B	CS-00	0		Septe	4 BER 16,	200 lp
7,	)	30. Name and address of person wh	o completed cau	ise of death (Ite	m 23a) (Type,	Print)						
		DR. STUBET KANA	EN 494	<b>937893</b> 0	EN AVE	DYC	BALTIN	DRE, M	D 21224	1		
	State	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	0 mg						
Regis	strar	CED 1.9	2005	MA-A	K A	hash	7					

DHMH 17 Rev 1/2001

			1 For State		aryland / Dep	artment of I	Health an	d Mental Hyg		
			Registrar  1. Decedent's Name (First, Middle, La	st)	Ce	rtificate of	, Deain	2. Date of Dea		3. Time of Death
	Physici	an	FranciszeK			OF	104			065:17P. M
1	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town,	or Location of D		4c. County of De	
	LAGITIII		Johns Hopkins			Ва	1timor	e	n/a	
	Funeral		5. Social Security Number 6. S		θ (In yrs. last birthday,	If Under 1 Year Months Days		Hrs. 8. Date of Birtl (Month, Day OCt25	h 9. B	irthplace (State or Foreign Country) Dland
	Director		037-42-0310	1 X M 2 L F	91 Yrs.			0ct25	,1914   Po	land
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary of ah	ģ	Md. n/a		Balti	more				1 Yes 2 □ No
	h the	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
	death with the Marylan me 23a or 28a-f ahow	Funeral Director	408 South Ches	ter Stree	et	212	231		USA	
	r dea	nei	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Arr Black, Wh	
36	s afte	by Fi	1 № Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🖔 1 If Yes, Give Year or Dates:	No	1□Yes 2∕□No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or itame 28a or 28a-f ahow the diest Exactinar mant be notified at	ed	15. Decedent's E		16a. Dece	dent's Usual Occu	pation	1	16b. Kind of Busines	s/Industry
215	nin 72	Completed	(Specify only highest gr	ade completed) College (1-4or 5	(Give	kind of work done DO NOT use retire	during most of ad)	working		,
21	or the	E O	Elementary/Secondary (0-12)	5+	Pri	est			Catholic	Church
pu	tat Hy d oth	Be	17. Father's Name (First, Middle, Last Franciszek Okt					Name (First, Middle,		
yla	ould Men varka vatic	2						adia Ster		· - · · · · · · · · · · · · · · · · · ·
Maryland	12 sh h and 7 ie n traun	1	19a. Informant's Name/Relationship (						r, City or Town, State,	
	1 and Healt am 2		Fr. Richard Ph	iliposki,	20h Place of Dien	action (Mama of		it. Balti	more, Mar	yland21231 rTown, State
<u>o</u> u	ages ant of st: If it		Maurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Holy Ro	matory or other pla sary Ce	m. 9/	/22/2006	Baltimor	e,Maryland
Baltimore,	nit. Fourtme	l	21 Final re of Funeral Service Lice			-	, - ,			1 Home, PA
m	P P P P		Sailes & Mess	susk						ryland2122
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li						Approximate Interval Between
4	Physician		Immediate Cause (Kinal disease or condition	. In	tracrani	al He	marrh	1214		Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	0	7 '		(A)	1
1		1	Sequentially list conditions,	b. Due to (or as	Amatic	Smin_	LYJU	7		6 days
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 20	2 33.133 423.133 31,		1,50	10	MER	
ć	te be executed ysician and e burial-transit	Еха	resulting in death) Last	c. Due to (or as	a consequence of):	C	77	(b)	CAL	
	2 2 9	cal		d			-/- 1	<u> </u>	MEDIL.	
89	ntifica ing ph e as th	Med	IF FEMALE:			-	1	opp	LED L	
Вох	eath certificat attending phy I for use as the	lan/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	y C	TATION AT	23d. Date of d	elivery Day Year
0	the the	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _		CERTEU	Worth	Suy Tour
P.0	that the ed by detac		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Vital Records,	uires sign	d by						1 🗆 Y	es 2□No 3□F	Probably 4 Munknown
S	aw requir 1s been si 2 should	Completed					w .	24a. Was a	an 24b. Were a	utopsy findings available
Re	: The la cete has page 2	E O						autop perfor 1 ☐ Yes	med? prior to death?	completion of cause of
ital	sician: Th certificete rector, pag	BeC	25. Was case referred to medical				26. Place of	Death (Check only or	A	3 28 110
<b>ŏ</b>	Phyeic this ce al dire	To	examiner? 1∭ Yes 2 □ No	Hospital:	ent 2 EP/Outpatie	nt 3 DOA	her: 4 🗆 Nursir	ng Home 5 ☐ Resid	ence 6 □Other (Sp	ecify)
E O	ding Ph th.: After th tuneral	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) Injury	Wo	rk?	- 1	ow injury occurred	etaire
isic	Attending Physician: r death. sector: After this certifict by the funeral director,	lcat	2   Accident investigation 3   Suicide 6   Could not be	e 290 Place of Ini	1001		Yes 2 □ No	,	t bottom os	
Division	after Direction by	Certification:	4  Homicide determined	building, et	ury - At home, farm, st c. <i>(Specify)</i> ROSAYY (	hurch		City or Tow	treet and Number or F m, State) fex St. Balti	more, MD 21231
	spita nours nerai / fillec		29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowledge, deal	h occurred at the ti	me, date and p	lace, and due to the o	ause(s) and manner a	as stated.
	To the Hospital or Attend Within 24 hours after death To the Funeral Director: completely filled in by the t	edicai	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	f examination and/or in ated.	vestigation, in my	opinion, death o	occurred at the time, o	date and place, and du	e to the cause(s)
	or or lead	Σ	29b. Signature and title of certifier	1116	MO	29c. Licen		. 1	29d. Date signed (Mor	
		( )	Tamer Who	remor	111	. (	5-00		September	
(	)		30. Name and address of person who Tamer Abde.	completed cause of d	eath (Item 23a) (Type	Print) P & trop	+ Ro	ltimore 1	MD 212	87
7	Sta	te	31. Date filed (Month, Day, Year)	32. Resistr	ar's Signature	1 .		1	10 -1-	
	Registr	ar	SEP 1 9	2006	HAN ST J	Server)				

		•	For State Registrar	State of Ma	ryland		artment of H tificate of L		and M		ene , g. No. (	200	6 29	654
П	Physici	20	1. Decedent's Name (First, Middle, La	ist)						2. Date of Death Month	Day	Year	3. Time o	
	/Medic		Virginia	rerry						Sext	13	2006		OPM
1	Examin	er	4a. Facility Name (If not institution, give	4			4b. City, Town, or		f Death			ounty of Dea	ath	
	<del></del>		5. Social Security Number 6.5		(In ure la	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth	N	IA	rthplace (State	or Foreign
7	Funeral Director			1 ☐ M 2 【XF	64	Yrs.	Months Days	Hours	Min.	(Month, Day, 2-5-42	Year)	9. 6	S.(	
	ס		Usual Residence of Decedent							2 3 12				
	urylan show	_	10a. State 10b. County		-	, Town or Lo							10d. Inside C	
	8a-f	Director	Md. NA			Baltim								2 🗍 No
	illed within 72 hours after deeth with the Maryland Hyglene, ther than "natural", or items 23s or 28s-f show that the Medical Examinat must be notified at	급	10e. Street and Number	Arranua			10f. Zip Code 21215			10	g. Citize US	en of What C ≳∆	ountry?	
	leeth ns 23	Funeral	2772 Virginia 2	12. Was Decedent E	ver in U.S	S. 13. V	Was Decedent of Hi	spanic Orio	nin? (Spe	cify Yes or No-			erican Indian,	
20	after or item		1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		1	f Yes, specify Cuba	n, Mexican	, Puerto f	Rican, etc.)		Black, Wh		
5-0036	rai', c	d by	3 Widowed 4 Divorced	If Yes, Give 25 Year or Dates:			1 □ Yes 2 No	Specify:			S	ipecify:	Black	
2	72 h natu	Completed	15. Decedent's E (Specify only highest gr			(Give	lent's Usual Occupa kind of work done of	turina most	t of workir	ng 1	6b. Kind	d of Busines	s/Industry	
12	within ane. than	du	Elementary/Secondary (0-12)  11th grade	College (1-4or 5-	+)		oo NOT use retired	)			NA	4		
d 21	Hygid Hygid Sther ant,		17. Father's Name (First, Middle, Last	()			Jabica	18. Mothe	r's Name	(First, Middle, M				
Maryland	lid be fental rked o	To Be	James		Redd	lin		M	artha	a	Boy	kin		
ary	s 1 and 2 should be filed within 72 hours after deeth with the Marylan Health and Mental Hygiene. Health and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-f show tiem 27 is marked other than "natural" or high and the motified at		19a. Informant's Name/Relationship	(Type, Print)			g Address (Street a							
	# 2 g g		Terena Perry	Daughter	,		3 S. Bal	lou C			e, M	1d. 2	1239	
altimore,	0 0		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐	☐Removal from State	20b. PI	lace of Dispo emetery, cren	sition (Name of natory or other place	e)	D	ate 2	0c. Loca	ation - City o	r Town, State	
Ē	t. Partmen		* 4 ♣Donation 5 ☐ Other (Speci		Tr	cinity			9–21	-06	Dune	dalk,	Md.	
Ba	permit, Page Depertment Important: If any injury or once.		21. Signature of Funeral Service Lice	w an	ت		Name and Addres		-	March F. , Baltin	H. I	East , Md.	21202	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death e.	. Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory arre	st,		Approxima Interval Be	tween
-	Pnysician		Immediate Cause (Final disease or condition	Small	cell	100	Canan						Onset and	
ß,	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ience 📆:								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	uence of):								
	ansit and	를	cause. Enter Underlying		,	,								
Ć	cate be executed  physician and the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	consequ	uence of):	· <del></del>		-					
8760,	ate be nysicia he bu	dical		d										
9	artifica ing ph e as th	(D) 1	IF FEMALE:								1			
Вох	The law requires that the death certificate has been signed by the attending Isologe 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 ☐ Fetal	death 3	Ectopic pregnancy				23	d. Date of de Month	,	Year
o O	res that the dei igned by the a be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of de	eath 5	Other (specify)						,	
٥.	that the ed by detac		Part II. Other significant conditions	contributing to death bu	it not resu	ulting in the u	ndertying cause give	en in Part I.		23e. Did tob	acco use	e contribute	to the cause of	death?
Records,	puires n sign ald be	d by	Renal Insulfa	leeny						1 ☐ Ye	s 2 🗆	No 3∏£	robably 4	Únknown
000	s been si should i	ojete	Hy pertusion	0						24a. Was ar		24b. Were a	autopsy findings	available
æ	The lav	Completed	Chronic anom	ia						autopsy perform		death?	completion of o	cause of
ta		Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check only one		, , ,	2 2 110	
<u>×</u>	hysic his ce il direc	To	1 ☐ Yes 2 No	Hospital: 1   Inpatie	nt 2 🗆 I	ER/Outpatier	t 3□ DOA Othe	BIT 4 X Nu	rsing Hor	ne 5 🗆 Reside	nce 6	□Other (Sp	ecify)	
ū	ding Ph h, After th funeral	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury	Work	</td <td></td> <td>28d. Describe ho</td> <td>w injury</td> <td>occurred</td> <td></td> <td></td>		28d. Describe ho	w injury	occurred		
S	ttend deeth stor: / the f	icat	2 Accident investigated 3 Suicide 6 Could not 6	be Ope Bloom of Init	n. At bo			Yes 2□		28f. Location (Str	ant and	Alumbaras	Pural Cauta Alia	
Division of Vital	after after Direct In by	Certification;	4 ☐ Homicide determined	building, etc	Specify	nne, rarm, str /)	eet, factory, office		Í	City or Town	State)	NUMBER OF F	iurai rioute ivui	n <i>ber</i> ,
	To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifical completely illed in by the funeral director.	edical C	(Check only 2 Medical Exa	hysician: To the best o	examinat	wledge, death	n occurred at the tim vestigation, in my of	ne, date an pinion, dea	d place, a	and due to the ca	use(s) a te and p	nd manner a	is stated, se to the cause(	s)
	o the ithin 2 o the implel	Med	29b. Signature and title of certifier	and manner sta	100.		29c. License	a number		29	d. Date	signed (Mor	nth, Day, Year)	
1	F 3 F 8			1ma				3129.	_					
•	1	1	30. Name and address of person who		eath (Item	23a) (Type					- /	17/0	6 1d 21.	
	P		Wendy Kloes	2 m0 (	070,	/ /4 (	Print) You Us S	A 3.	Te .	4204	Bas	A re	nd 21.	204
	Sta	te	21 Date filed (Benth Day Vear)	32 Dogitte	r'e Ciana	turn								
	Regist	ar	SEP 1 9	2006	un	18 p	greater							

State of Manyland / Department of Health and Mental Hygiene 2006

			1 - State Registrar	State of Mai		ertificate of			eg. No.	29633
	Physicia	an	1. Decedent's Name (First, Middle, Thomas James Pi	•	r			2. Date of Death	er <sup>Day</sup> 15, 200	3. Time of Death 7:15 a M
	/Medic Examin		4a. Facility Name (If not institution,		· · · · · · · · · · · · · · · · · · ·	4b. City, Town, o	r Location of Death	Версешь	4c. County of Dea	
di .	LXdiiiii	ان. د	612 Deep Ridge	Road		Be1			Harfor	
	Funeral Director		153-07-6969	7. Age	(In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 3,	9. Bir 1916 Pe	thplace (State or Foreign ountry) nnsylvania
3	III IOM		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
-	a-feh	ctor	Md. Harf	ord	Be1	Air				1 ☐ Yes 2X No
1	or 28	Dire	10e. Street and Number			10f. Zip Code	2101/	10	Og. Citizen of What C	ountry?
1	ns 23¢	Funeral Director	612 Deep Ridge  11. Marital Status	12, Was Decedent Ev	rer in U.S. 13	3. Was Decedent of H If Yes, specify Cuba	21014 dispanic Origin? (Sp	ecify Yes or No-	U.S.A.	erican Indian,
	should be lead which 72 hours after beath with the maryland Mandal Hygiene. The Maryland State of 1864	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?  1 □XYes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Puèrto Specify:	Rican, etc.)	Black, Whi	
	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec (Giv	edent's Usual Occup re kind of work done . DO NOT use retired	ation during most of work	ing	16b. Kind of Business	/Industry
7	z snoud be filed within and Mental Hygiene. Is marked other then eumatic event, Inc. M.	dwo	Elementary/Secondary (0-12) 12 years	College (1-4or 5+	)	security	3)		safety (C	Courthouse)
2	other vent, I	Be C	17. Father's Name (First, Middle, La	ist)		Becaries	18. Mother's Nam	e (First, Middle, N		
<u>X</u>	Ments arked	ToE	(unknown)					ellina P		
Na.	7 Is m treum		19a. Informant's Name/Relationshi			-			City or Town, State, Md. 2101	· ·
ָט .	f Heall fem 2 stem 2 other		Doris Pitcherel 20a. Method of Disposition		20b. Place of Disp	position (Name of ematory or other place	201	Date 2	20c. Location - City or	Town, State
	permit - rages i and s should by permit - rages i and s should be perment of Health and Menta Important: If Item 27 is marked eny injury or other treumatic evonce.		1 🔀 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe	ocify)		w Mem. Gdi		/2006	Fallston,	Md.
Dall	Depart Depart Import eny inj		21. Signature of Funeral Service Li	- ~ P	10 -	22. Name and Addre Schimunel	Functal	Home of	Bel Air,	Inc.
Ä,	*		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caused the	ne death. Do not e	nt 10 mode of Mir	reFirst1 R	or respiratory arre	Air, Md.	21014 Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	L un	& Care	es				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	nsequence of):					3
	V32 . Ž	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
	ansit	Examin	Sequentially list conditions, if any, leading to immediate causes. Enter to recrying Cause (Disease or injury that initiated events	c						
5	incate be executed ig physician and as the burial-transit	I Ex	resulting in death) Last	Due to (or as a	consequence of):					
0	physic s the b	edlcal		d						
O. DOX	To the hospital or Attenuing Frigerien. The law requires that the death certificate be executed within 24 house state death.  To the Funerel Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of de Month	livery Day Year
	ned by	by Ph	Part II. Other significant condition	s contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
5	been sig	ted b						1 Z Ye	s 2□No 3□P	robably 4 Unknown
יייייייייייייייייייייייייייייייייייייי	nyercien. nis certificate has be I director, page 2 sh	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
A 10	certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one		
5 8	After this funeral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	2 ☐ ER/Outpati 28b. Time	of 28c. Injur	y at	28d. Describe ho	nce 6 Other (Spe w injury occurred	ecify)
5	tor: After tun	atlo	1 Natural 5 Pending 2 Accident investiga	tion	Ye <i>ar)</i> Injury		Yes 2□No			
בובי ביים ביים	rs after de el Directo ed in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin		y - At home, farm, s (Specify)	street, factory, office		28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	no the nospitet of At within 24 hours after of To the Funerel Direc completely filled in by	edical	(Check only 2 Medical E.	Physicien: To the best of caminer: On the basis of e and manner state	my knowledge, dea examination and/or ed.	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ite and place, and due	s stated. e to the cause(s)
1	Ton	Σ	29b. Signature and the of certifier	at al. II		29c. Licens	e number	29	Date signed (Mont	in, Day, Year)
5			30. Name and address of person w	1600	ath (Item 23a) (Type	e. Print)	1.50	· C/	1700 R	110/237
	Sta Registr	- 9	31. Date filed (Month, Day, Year) SEP 1 9	32 Registrar 2006	s Signature	Jun L	11 - 4. D	1- 20-0	100 []a	18, 2006 1/40 MD

06-06759 James Paylor

#### Please Type or Print in Black Indelible Ink

James Paylor State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day September 8, 2006 0940 hrs Medical Examiner 4c County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Maryland General Hopsital 9. Birthplace (State or 5. Social Security Number 7 Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) **Funeral** oreign 0884 50 4-26-1956 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State Yes 2 No or 28a-f show hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? arrollt or items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, 8lack 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes No Yes 2 No specify If Yes, Give Year Divorced Specify: Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiens. The tent of Health and Mental Hygiens. If iten 72 is marked other than "natural", or other traumatic event, the Medical Examiner. Widowed 4 ₽ r Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tadu Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, 19b. Mailing Address Apt.p 2412 20a. Method of 20b. Place of Disposition (Name of cemetery 20c Location crematory or other place) Important: injury or oth Comeller P. march Runeral Home complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). and Physician/Medical X UNPENDED AMENDED item#23a.PTT 27. nerME\_0859\_9/20/06\_TT Box 68760 23c If yes, outcome of pregnancy IF FEMALE 23d Date of delivery 23b Was decedent pregnant in the Live birth Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. à Yes 2 V No 3 Probably 4 Chronic drug use Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 1 V Yes 2 28c Injury at Work? 28d Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No Pending Fo the Funeral Director: 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a Certifier 1 Certifying Physiciany To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examine one) h the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title certifie O.C.M.E. September 9, 2006 ss of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) 32 Registrar Signature Registra CED

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State of Maryland / Department of Health and Mental Hygiene		11		r
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			1 - For State Registrar	State of Marylar		rtment of H			iene 2006 •g. No.	29657
	Physici		Decedent's Name (First, Middle, Last)     Bessie Naomi Pumme	ery				2. Date of Deat Month Septemb	th Day Year	3. Time of Death 7:00 Ам
	/Medio Examir		4a. Facility Name (If not institution, give si Stella Maris Hospic	treet and number)		4b. City, Town, or Timoni			4c. County of Death Baltimor	
	Funeral Director		5. Social Security Number 214 18 1173 6. Sex 1□	7. Age (In yrs. M 2⊠F 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year) Cou	place (State or Foreign intry) yland
_	ith the Maryland or 28a-f ehow	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore  10e. Street and Number	9	ty, Town or Loc	sedale 10f. Zip Code		1	0g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2X No untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other treumatic event, the Medical Examinal medical once.	by Funeral Director	2316 Hamiltowne Cir  11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	CCLE  2. Was Decedent Ever in U Armed Forces? 1	- 11	212 Vas Decedent of H Yes, specify Cuba  ☐ Yes 2☒ No	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	USA  14. Race - Amer Black, White  Specify: Whi	, etc.
Maryland 21215-0036	iled within 72 ho dyglene. ther than "natur nt, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	ent's Usual Occup kind of work done OO NOT use retired emaker	during most of v	vorking lame (First, Middle, I	Own Home	ndustry
yland	nould be fi 3 Mental H narked ot natic ever	To Be	Frederick Osterman	B : 4)	101.11.71		Bessie	Hughes		
	1 and 2 st Health and Bm 27 Is n ther treun		19a. Informant's Name/Relationship (Typ Carole Bruzdzinski 20a. Method of Disposition	(Daughter)		Hamiltown		e Baltimo	; City or Town, State, Zine, Maryland 20c. Location - City or T	21237
Baltimore,	t. Pages rtment of l rtent: If its		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Oa	сөтөtөгу, сгөп ik Lawn	Cemetery	9/2	20/2006	Baltimore,	
Bal	Depar Impor		21. Signature of Funeral Service License  3. Signature of Funeral Service License  23a. Part 1. Enter the disease, or complice	kousk	14	10 / OTa F	astern		sex, Maryla	and 21221
8760,4	Physician /Medical Examiner but specified and the policy the policy the policy that the policy	dical Examiner	Isbock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	PNEUMONIA  Due to (or as a consecutive to (or a))).	quence of):					Interval Between Onset and Death
.O. Box 6	w requires that the death certifica been signed by the ettending of should be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	Sc. If yes, outcome of pregn.  1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	very Day Year
rds, P	luires that n signed b		Part II. Other significant conditions cont	tributing to death but not res	sulting in the ur	derlying cause giv	en in Part I.		pacco use contribute to	
al Records,	The law ete has b page 2 si	Completed						24a. Was a autops perforr 1 \( \text{Yes} \) 2	prior to or death?  K No 1 Yes	opsy findings available ompletion of cause of
of Vital	> 0	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No  27. Manner of Death	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien	3□ DOA Oth	er: 4 🗆 Nursing		e) ence 6X1Other (Specow injury occurred	fy) HOSPICE
Division	or Attending ifter death. Director; After in by the fune	Certification:	1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)  28e. Place of Injury - At h building, etc. (Speci	Injury		va° Yes 2 □ No		reet and Number or Rui	ral Route Number,
	he Hospital n 24 hours a he Funerel i pietely filled	edicai		ician: To the best of my known:  er: On the basis of examination and manner stated.						
	To the within 2 To the complete	×	29b. Signature and title of certifier			29c. Licens	3725	2	9d. Date signed (Month)	/
	(D)		30. Name and address of person who cor  DR • TARIQ MAHMOOD	2300 DULANI	EY VALL		rimonium	M, MD 2109	3	
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Sign	11 Ano	Als I				

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7:00 а.ш.

SEPTEMBER 17, 2006

BESSIE PUMMERY

State of Maryland / Department of Health and Mental Hygiene 200629658 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Jun 6 **Physician** EDWIN RIVERA 17 5:10 AM /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPITAL BALTIMONE, MD 21223 N/A If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) May 10, 1962 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2 ☐ F 44 Yrs. Maryland Director 113-52-1229 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene, important, or Items 23a or 28e-f show important: if item 27 is marked other than "natural", or Items 22a or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at aging. Y☐ Yes 2☐ No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2217 North Dukeland Street 21216 **USA** Funeral Pages 1 and 2 should be fited within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1

Never Married 2 ☐ Married ¹ŒYes 2□No Specify: Puerto Rican Baltimore, Maryland 21215-0036 Specify: Hispanic Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 12 Automotive Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luis Rivera Rosa Rodriguez ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Emma Eyler, Sister 664 Johann Drive Westminster, Maryland 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 09/18/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOOK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): BACTERIAL PERITONITIS Examiner SPONTANEOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed, burial-transit HERATITIS attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by CIRRHOSTS 1 Yes 2 No 3 Probably 4 Unknown COAGULO PATHU 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No this Certification; To After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Medical 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) i. nowhels, non Janet 9/17/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IANIET 11. MOGHEST 1, MD DOW W. BARTIMERE ST; BARTIMENE, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2006

Registrar

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Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last, RAIZEL  4a. Facility Name (If not institution, give)  Sinai Hospit	street and number)	R	OZWASKI  4b. City, Town, c	or Location of Death	2. Date of Death Month Septem be	Pay Year Year 18, 2001	
Funeral Director		5. Social Security Number 6. Security Number 1060-64-0138		yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	nplace (State or Foreign untry) NY
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  N/A		c. City, Town or Lo	cation IMORE				10d. Inside City Limits 1    Yes 2   No
with the	i Direc	10e. Street and Number 3913 FALLSTAFF R0	AD		10f. Zip Code	21215	10	g. Citizen of Whal Co	untry? USA
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or items 23a or 28a-f show event. Ite Medical Examinar must be natilled at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☼ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dales:	ŀ	Vas Decedeni of H i Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
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Id be filed lental Hyg	To Be C	17. Father's Name (First, Middle, Last) MICHA		OPPE	NHEIM	18. Mother's Name	e (First, Middle, M		NDERS
Marylis of 2 should th and Mer 27 is marke	F	19a. Informant's Name/Relationship (7)						City or Town, State, Z RE, MD 212	
I Fages 1 and the strain of Healt rant: If Item 2 qury or other:		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 📶 4 □ Donation 5 □ Other (Specify)	2	20b. Place of Dispo cematery, created IAR HAMNE	patory or other pla			Oc. Location - City or	rown, State
Physician /Medical Examiner	liner	21. Skhalfre of Funeral Service Libers 23a. * art1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	partons that caused the of cause on each line.  a. Second  Due to (or as a co	death. Do not ent ary Monsequence of):	er the mode of dy	TERSTOWN I	ROAD - P or respiratory arre	ON & BROS. IKESVILLE, st.	
b. O. Box 68/60,  at the death certificate be executed by the attending physicien and itserbed for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last	Due to (or as a co	oregnancy	Ectopic pregnanc	cy		23d. Date of del Month	very Day Year
dS, P.O	۵	Part II. Other significant conditions co						acco use contribute lo	the cause of death?
Hecor The law reques has been age 2 should	Completed	Previous Per					24a. Was ar autops perform	24b. Were au	lopsy findings available completion of cause of
r VICAL Pysician: Thysician: The is certificete director, pag	To Be	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA O	har	h (Check only one	nce 6 Other (Spe	cify)
On Of ding Physith. After this funeral di		27. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	28c. Inju		28d. Describe ho		
DIVISION I or Attending after death. I Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$		reet, factory, office		28f. Location (Str City or Town	eet and Number or Ru , State)	ıral Route Number.
Division of VIta Youthe Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of miner: On the basis of ex	amination and/or in	h occurred at the t vestigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
To the within To the comp	Z	29b. Signature and title of certifier	Mis			5 -000		ed. Date signed (Monte	
12		30. Name and address of person who de					Bac	inore	18,2006
S1 Regis	tate trar	31. Date filed (Month, Day, Year)  SEP 1 9 2	32. Registrar's	Signature	bark				

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	₹ 4 <u>2</u>	Physici	an	. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year 2006	3. Time of Death 6:51 A M
		/Medic Examin	al	Delores Jean Ruddle La. Facility Name (If not institution, give street and COOD SAMAR FRAN NO	SITAL			Town, or BAC	Location of	of Death	01	4c. County		
		Funeral Director		5. Social Security Number 6. Sex 1 □ M 2√ F	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 7 - 30 -	(, Year)	9. Birthp Cour	place (State or Foreign ntry) NY
		laryland show	ō			, Town or Lo	ocation						1	0d. Inside City Limits 1 Yes 2 No
~		death with the Maryland ims 23e or 28e-f show ir must be notified	Direct	10e. Street and Number 121 A Philadelphia		рра	10f. Zip	Code				10g. Citizen of	What Cour	ntry?
OR		be filed within 72 hours after death with the Marylan stal Hygiene. ad other than "natural; or Itams 23a or 28a-1 show event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 12. Was D	ecedent Ever in U.S Forces? s 2 2 No	S. 13.				igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Rac Bfa	ce - Americ ck, White,	can Indian, etc.
306	9000	within 72 hours after ene. than "natural", or Ita	ed by F	JY If Yes,	Give r Dates:	16a Dece	1  Yes	al Occup	ation			Specifi 16b. Kind of B		ite
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UDDL	and 2	I be filed withintal Hygiene. ad other there: event, If a M	Be Co	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,			115 6
8 0	Maryland	d 2 should be th and Mental 7 Is markad c traumatic eve	10	Unknown Eckleston  19a. Informant's Name/Relationship (Type, Print)					an <i>d Numb</i>	er or Rura	l Route Numbe			
		ss 1 and of Heall itam 2		Lisa Almsteadt — Da 20a. Method of Disposition 1□Burial 2台Cremation 3□Removal fr	20b. Pl	L∠I lace of Disperentery, cre	osition (Na	me of	- 1	7-5-	ate	20c. Location	- City or To	
	Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Ва	yview   2   P	Cra 2. Name a A 2	mat nd Addre	ory ss of Facil	_		Balti Ashton Road		eral HOme
_				23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final	n each line.									Approximate Interval Between Onset and Death
		Physician /Medical Examiner		disease or condition resulting in death)	to (or as a consequ		CCIV	)	10 :	LCE	10			
		pe tisi	iner	f any, leading to immediate cause. Enter Underlying	to (or as a consequence of the c	uence of):	ECU	2111	05 (	icce				
NE	3760,	eath certificate be executed attending physician and for use as the burial-transit	licai Examiner	that initiated events c	PARAPLE to (or as a consequ Spinal Co	uence of):	farct			9	/ ams	THE WALL EXAL	NINER	
13	P.O. Box 68	e d he d	Physician/Med	in the past 12 months?	outcome of pregna ve birth 2   Fetal egnant at time of de aknown	death 3	□Ectopic p		y C	INTERNATION AND AND AND AND AND AND AND AND AND AN	J. G. VORFFROV. D. E		ate of deliv	ery Day Year
Lax		uires that th signed by Id be detach	ò	Part II. Other significant conditions contributing	o death but not resu	ulting in the	underlying	cause giv	en in Part	l.				the cause of death?
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	ta	ysician: The lis certificate hadirector, page	BeC	25. Was case referred to medical examiner?							h (Check only o	ne)		
	<u>&gt;</u>	> ~ 0	10	Yes 2 No Hospital:	☑Inpatient 2□					lursing Ho	me 5 Resid			fy)
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		the Hosp in 24 hou the Fune ipletely fi	ledicai		the best of my kno ne basis of examina nanner stated.	tion and/or	investigatio	n, in my o	opinion, de	ath occur	red at the time,	date and place	, and due	to the cause(s)
•		To Toor	Σ	11900001.001	(D _	1 Stay	to		Se number			29d. Date sign		2006
	_			30. Name and address of person who completed MARWAN ABOUGE	26I. 6	400	S A	MAR	ITH	7\	HOSPI	TAL		
		St Regist	ate	31. Date filed (Month, Day, Year) SFD 1 5 2006	2. Registrar's Signa	ture								

			- State Amend item#1,per	State of Maryland / Dep. MD, 6860, 10/12/06 TF Ce	artment of Health and rtificate of Death	Mental Hygier	ne 2006 2966 I
	Physici	an	1. Decedent's Name (First, Middle, Last)  Mary Catherine	,		2. Date of Death Month	Day Year 3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give:	street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death  HARFAR  9. Birthplace (State or Foreign
Н	Funeral Director			M 2XF 69 Yrs.	Months Days Hours Mir		9. Birthplace (State or Foreign Country) 1937 PA
	and #		Usuaf Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. fnside City Limits
	Maryl	tor	MD Harford	Bel Air			1 ☐ Yes 2. ☐ No
	vith the	Director	10e. Street and Number	0.1	10f. Zip Code 21015	10g. (	Citizen of What Country? USA
	me 23	Funeral	2710 Bynum Hill	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - American Indian,
036	J within 72 hours after deeth with the Maryland jiene. r then natural', or terme 23a or 28a-f ehow I'r a Musical Ezam, at musi be incilled at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√☐ No	ff Yes, specify Cuban, Mexican, Pue 1 ☐ Yes XXNo Specify:	rto Hican, etc.)	Specify:White
15-0	"natu	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Give	edent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking 16b.	. Kind of Business/Industry
212		omo	Elementary/Secondary (0-12)	College (1-4or 5+)	emaker	Ow	vn Home
Maryland 21215-0036	ntal Hygi ed other event, 1	Be	17. Father's Name (First, Middle, Last) Alonzo Getz			ame (First, Middle, Maid ced Collin	
aryli	s 1 and 2 should I f Health and Meni ttem 27 is marked other treumatic	ဥ	19a. Informant's Name/Relationship (Ty		ing Address (Street and Number or F		
	1 and 2 Health a tem 27 to		David B. Smith,	2710	- September 11 - 11 - 11 - 11 - 11 - 11 - 11 - 11		Air, MD 21015
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 Burial 25 Cremation 3 P	lemoval from State	matory or other place)		Location - City or Town, State
altir	permit. Pages Department of timportant: If the any njury or of		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		rematory, Inc.  2. Name and Address of Facility remation Socie		
8			16.6kg		99 Frederick F	d Baltimo	ore. MD <sub>-</sub> 21228
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Finaf	ications that caused the death. Do not en ne cause on each line.	iter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate fnterval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	it (olan can	PP	
ı	Examiner	_	Esquentially list sunditions,	Due to (or as a consequence of):	rancon		6 mater
	d A d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence or).			
90,	cate be executed the physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):			
68760,		edical		d.	_		
Вох	requires that the death certific seen signed by the attending f hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.O.	quires that the signed by aid be detacted	٥	Part II. Other significant conditions con	ntributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	2 No 3 Probably 4 Unknown
Vital Records,	e law has t	Completed				24a. Was an autopsy performed	
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only one)	
o	ding After fune	tlon: To	1 Yes 2 X No  27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  2 □ ER/Outpatie 28b. Time of Injury Injury	RIL 3L DOA 4 RAUTSING	Home 5 Residence 28d. Describe how in	
Division	ospital or Attending hours after death. unerel Director: Aftel ly filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C		sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.			
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)
	1		Dra.	Iller onn	127975		9/19/06
	Y		A 10	ompleted cause of death (Item 23a) (Type	Very Phail Ad A	rel Rin	en 21014
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	na part pd p	1111/	VIII VIII
	Regist	rar	SFP 1 9 21	OUO POSSESSES			

DHMH 17 Rev 1/2001

	1		artment of Health and Me rtificate of Death	ental Hygien Reg. N	····
Physicia	n	1. Decedent's Name (First, Middle, Last) BETTY D. SHOEMAKER		2. Date of Death EPTEMBER D	<sup>3</sup> . Time of Death 3:30 P. M
/Medica Examine		4a. Facility Name (If not institution, give street and number)  119 NORTHDALE ROAD	4b. City, Town, or Location of Death GLEN BURNIE		c. County of Death ANNE ARUNDEL
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday 1 1 M 2 X F 78 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.   J	8. Date of Birth (Month, Day, Yea ULY 18, 1	9. Birthplace (State or Foreign Country) MARYLAND
iryland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L			10d. fnside City Limits 1 ☐ Yes 2 🛣 No
th the Ma or 28s-1 s	Director	MARYLAND ANNE ARUNDEL GLEN BUT	10f. Zip Code	10g. C	Citizen of What Country?
23a c	a D	119 NORTHDALE ROAD	21060		IITED STATES
036 urs after dez al', or Itama	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If Itam 27 is marked other than "natural; or Itama 23e or 28e-1 show any injury or other traumatic event, the Madical Examinational be multified at once.	Completed	(Specify only highest grade completed)  (Giv  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of workin DO NOT use retired) MEMAKER		Kind of Business/Industry  OWN HOME
land 2 Id be filed ental Hygi ked other Ic event,	To Be Co	17. Father's Name (First, Middle, Last)  GEORGE DIX	18. Mother's Name	(First, Middle, Maid	
Maryland d 2 should be file th and Mental Hy Z 1s marked oth traumatic event	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rura.  19 NORTHDALE ROAD	Route Number, City GLEN BURN	_
altimore, mit. Pages 1 an partment of Heal portant: if Itam 2 y injury or other		20a. Method of Disposition  14 Rurial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, critical contents of the content	ematory or other place) SEPT	20	Location - City or Town, State EN BURNIE, MD
Baltir permit. P Departme Importen any injur.		21. Signature Funeral Service Licensee	22. Name and Address of Facility IRKLEY-RUDDICK FUNE 21 CRAIN HWY. S.E.	ERAL HOME	P.A.
Physician /Medical Examiner bhisician and bhisician and sthe purial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expected a shock, or heart failure. List only of elease on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Spindle Coll		Approximate Interval Between Onset and Death Month
Records, P.O. Box 68 The law requires that the death certifics tte has been signed by the attending pl bage 2 should be detached for use as it	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	þ	Part ff, Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Vital Records, sicien: The taw requires to certificate has been signe rector, page 2 should be	Completed	JI		24a. Was an autopsy performed	
Vital F	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
Of Phys ration	ıtlon: To	1   Yes ZENo Hospital: 1   Inpatient 2   EP/Outpati  27. Magner of Death  YENatural 5   Pending 2   Accident investigation   28a. Date of Injury (Month, Day Year)   28b. Time Injury	of 28c. Injury at	ne 5X Residence 28d. Describe how in	e 6 □Other (Specify)  njury occurred
Division ospital or Attending hours after death. uneral Director: After ly filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
Divi To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th within To th comp	M	29b. Signature and the of constitution of the	29c. License number  D5 4 29	29d.	Date signed (Month, Day, Year)
6		30. Name and address of person who completed cause of death (Item 23a) (Typ S. JASSI 1600 CRAIN HWY	SUITE 610, GI	en Bunk	Mie, MD 21061
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1-11	-0	

DHMH 17 Rev 1/2001

SEP 1 9 2006 Steen & Ag

ORIGINAL

			1 - For State Registrar	State of Maryland		rtment of H			jiene •g. No. 20	06	29663
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		Sandra	Lee <u>Sapaner</u>	0			Septemb	er 17 20	006	7:45 A M
>	Examin		4a. Facility Name (If not institution, give str			4b. City, Town, o	Location of Dea	th	4c. County	of Death 1time	are
			Genisis Catonsvill	e Commons		Catonsvi	11e				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		Months Days	Hours Min		Year)	Count	ace (State or Foreign try)
	Director		217-30-4270	63	Yrs.			Nov 22,	1942	Mary	/land
	and w		Usuaf Residence of Decedent  10a. State 10b. County	10c. City, T	own or Loc	cation				10	Od. fnside City Limits
	danyl f aho	ō	Maryland N/A		Balti	imore					1 X Yes 2 ☐ No
	the t	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Coun	try?
	3a or		2904 East Strat	hmore Avenue,	#2	2	21214-25	13	USA		
	be filed within 72 hours after deeth with the Maryland stal Hyglene.  do other then "naturel", or Itams 23a or 28a-f ahow avent, the Medical Examiner must be notified at avent, the Medical Examiner must be notified at	Funeral	11. Marital Status	. Was Decedent Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race	e - America k, White, e	
ထ	after or Ita	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No ff Yes, Give	(	Yes 2 No	Specify:	no moan, stc./	Specify		
8	Suno Pur	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:			орослу.			N	lhite
S D	72 h	Completed	15. Decedent's Educa (Specify only highest grade of		(Give	ent's Usual Occup kind of work done	during most of wi	orking	16b. Kind of Bu	siness/Inc	lustry
2	han o	ш	Elementary/Secondary (0-12)	Colfege (1-4or 5+)		OO NOT use retired	2)		Bonny D	120+1	cs, Inc.
Ż	tygie d'		17. Father's Name (First, Middle, Last)	0	Mac	chinist	18. Mother's Na	ame (First, Middle,			CS. IIIC.
and	t be filed ntal Hygi ed other avent, t	Be	Herbert Josep	h Brady			Elva	Nezbeth			
Maryland 21215-0036	2 should be i and Mental I is marked or raumatic ave	ဥ	19a. Informant's Name/Relationship (Type		19b. Mailin	a Address (Street		Rural Route Numbe			Code)
<u>8</u>	4 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Colein L. Fischbach	(Sister)	310	Piedmont	Court	Ocean Pi	nes Md	21	811
<u>ق</u>	s 1 and 2 should I Health and Men Itam 27 is marks other traumatic		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other place		Date	20c. Location -		wn, State
<u>o</u>	ages ant of t: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State			· 1	9/18/06	Raltimo	re. M	lary1and
Baltimore,	permit. Pages 1 and Department of Healt Important: If Itam 2 any injury or other once.		21. Signature of Funeral Saway Licensee								iar y rana
Ã	Depa Impo any i		0/2	- REVIN E EGRE	2	37 E. Pa	tapsco /	Funeral Ave., Bal	to., Md	. 21	225-1856
			23a. Part1. Enter the disease, or compfice shock, or heart failure. List only one	ations that caused the death.							Approximate Interval Between
	Physician		fmmediate Cause (Finat disease or condition	Dra	me	a Lu	ng G	ncer			Onset and Death
7	/Medical		resulting in death)	Due to (or as a consequer	nce of):		1				3
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7	n =	ner	n any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ica of).					1	
V	ocute nd trans	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	2						_	
ő,	ate be executed physicien and the burial-transit	ũ	1930Ming III Geatily Last	Due to (or as a consequer	ice oi):						
8760,	ate b	dical	d.								
9	eath certific attending p I for use as	0	IF FEMALE:	c. If yes, outcome of pregnanc	v				22d Dat	e of delive	IN.
Вох	attenc for us	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fetaf de 4 ☐ Pregnant at time of deat	ath 3	Ectopic pregnanc Other (specify)	у		Mo		Day Year
	he de	ysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unknown	3	Cities (specing)	2000				
P.0	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the		Part II. Other significant conditions cont	ributing to death but not resulti	ng in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use cont	ribute to th	ne cause of death?
ds	uires s sign ld be	d by						101	/es 2 □ No	3 ☐ Prob	ably 4 Unknown
Vital Records,	w requir	Completed						24a. Was	an 24b. \	Were auto	psy findings available
Re	The lav	Ĕ							rmed?	death?	mpfetion of cause of
ā		ŭ	25. Was case referred to medical				26. Pface of D	eath (Check only o	2007 100		22110
5	Physician: this certific ral director.	0	eyaminer?	spitaf:	3/Outpatier	nt 3 DOA Ott		Home 5 ☐ Resid		er (Specif	y)
o	g Physer this	E	27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time o	f 28c. Inju Wo	ry at	28d. Describe h	now infury occur	red	
0	ath. r: After se funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(1101181, 54) 754)	,ury		Yes 2□No				
Division	r Atta er de recto by th	Certification;	3 Suicide 6 Could not be determined	28e. Pface of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rura	l Route Number,
Ö	rs eft rs eft ral Di	Çe							-		
	To the Hospital or Attanding within 24 hours effer death.  To the Funeral Director: After completely filled in by the fune		(Check only 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination	n and/or in	vestigation, in my	opinion, death oc	curred at the time,	date and place,	inner as s and due to	tated. the cause(s)
	the I the I mplet	Medical	29b. Signature and title of certifier	and manner stated.	1+0	29c. Licen	se number		29d. Date signe	d (Month.	Day, Year)
	S X S		16 L	1) Here	m	カつ	(942		Seal-		2006
•	1		" Come	related cover of death //-	20\ T	Drint)	DITL	•	341	0 /	
	9		30. Name and address of person who con	My / CO	Jent (1ype,	levick R	D. Cato	wille,	mo 21	228	
	Ç.	ate	31. Date fifed (Month, Day, Year)	and manner stated.  A please of death (frem 2 and 2 Registrar's Signary)	re A	asti)					
	Regist		SEP 1 9 200	January 13.	AST.						

State of Maryland / Department of Health and Mental Hygiene. 29664 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day September 14, 10:35 PM M Physician June C. Schaum /Medical 4a. Fecility Name (If not institution, give street and number) 3510 Tarkington Lane 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

92 Months Days Hours Min. 8. Date of Birth (Month Day Year) 06/01/1914 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2 F 240-18-8203 Vre Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f ehow any injury or other traumatic event, it a Medical Examinar must be redified at ance. 1 ☐ Yes 2 No MD Montgomery Silver Spring Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906-3510 Tarkington Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Maggify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Education College (1-4or 5+) Elementary/Secondary (0-12) Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jake Crouse Mary Bare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack H. Schaum/Husband 3510 Tarkington Lane Silver Spring, MD 20906-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9-18-2006 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non Small Cell Lung Concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 ⊠Unknown Atter this certificate has been si funeral director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 € No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 18 2006 MDO 60335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #327 Philip Olney 18111 Bannen 31. Date filed (Month, Day, Year) State 2006 Registrar 9

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0 2006 42AM Rice Smith Omega /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITO1 01 39 nar 6 ff Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. Hours 1 ☐ M 2X F Yrs. Director 9/10/1921 237-34-2046 Tennessee Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be nutified at 1 ☐ Yes 2 TXNo Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 37 Berkshire Road 21221 S. Α. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: à 3 □XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker Factory permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If Item 27 is marked othe eny injury or other traumatic event, sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stola Rice Linda Dora ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Personal Essex, Maryland 21221
Date 20c. Location - City or Town, State Charles J. Scheuerman 20b. Place of Disposition (Name of cemetery, crematory or other place) 37 Berkshire Road Baltimore. 20a. Method of Disposition
1 🛱 Burial 2 □ Cremation 3 □ Removal from State 9/19 2606 4 ☐Denation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Maryland 21221 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lattacrania /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed signed by the ettending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 DUnknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? (es 2.0 No 1∏ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Pface of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA DIS. 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Alter Certification: Hospital or Attending 24 hours after death. 1 Natural 5 Pending Injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) License number 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 9000 Franklin Square 1. In ocent Monyo
31. Date filed (Month, Day, Year) -tamb 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 29666 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year Month **Physician** 11:55 AM September Wilbur Francis Schillenberg 15 5006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A HOSPITAL SAINT AGNES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 28, 1 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months Yrs. 219-18-2359 80 1925 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 17 is marked other then "natural", or iteme 23a or 28e-f show traumatic event, the Madical Examinat must be notified at 1 Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Iteme 23a or: 713 Maiden Choice Lane Apt. 1404 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Police Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Wilbur F. Schillenberg Catherine Smoot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 441 Majothy Bridge Rd., Pasadena, MD 21122 Michael Schillenberg, son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Loudon Park Cemetery 9-19-06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 execu 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CLASTROWTESTINAL BLEED **Physician** UPPER 12 Hours /Medical Due to (or as a consequence of) **Examiner** 12 Honry PNEUMONIA ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physicien and the burial-transit 3 MONTIH MYELODYSPLAS Due to (or as a consequence of): use as the been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ERTENSION 3 Probably 4 Hinknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No 1 Yes 21110 To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Matural 5 Pending 1 Tes 2 No investigation М 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-18613. September, 15,2006 Mayon  $M \cdot D$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD SAIM, 900 S- CATON AVE, BALTIMORE, MD -21229 SAIMI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 SEP 19 Registrar

			1 - For Stete Registrer	State of Maryland / De <i>C</i>	partment of Health ertificate of Deatl	and Menta h	al Hygiene Reg. No	200	6 29667
	Physicia	an	1. Decedent's Name (First, Middle, Last)				te of Death	y Yeer	3. Time of Death
	/Medic	ai	HANNAH		SANDLER  4b. City, Town, or Location			15 2006 County of Deat	9:30 P M
1	Examin	er	4a. Facility Name (If not institution, give str MILFORD MANOR NURS		BALTIMORE	n or Death	40	BALTIMO	
Ī	Funeral Director			7. Age (In yrs. last birthda 92 Yrs.	Months Days Hours	Min. (M	te of Birth onth, Day, Year, 17/1914	9. Bird Co	hptace (State or Foreign buntry) MD
	within 72 hours after death with the Maryland ene. then "netural", or fteme 23a or 28a-f ehow the Medical Examinat must be notified at	ctor	Usual Residence of Decedent	E BALTIMO					10d. Inside City Limits 1 ☐ Yes 2X☐ No
	vith th	Funeral Director	10e. Street and Number	ITLL DOAD	10f. Zip Code			tizen of What Co	ountry?
	ns 23s	eral	4204 OLD MILFORD M		21208 3. Was Decedent of Hispanic C	Origin? (Specify Y		J.S.A. 14. Race - Ame	erican Indian.
036	urs after d al', or iten Examinar		Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give X Year or Dates:	3. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Specif		etc.)	Black, Whit	e, etc. WHITE
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mentai Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23a or 28a-f ehow any injury or other treumatic event, Ita Medical Examinar must be rediffed at once.	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Gi life College (1-4or 5+)	cedent's Usuat Occupation we kind of work done during mo b. DO NOT use retired)	ost of working		(ind of Business	
d 21	be filed water Hygier of other the		17. Father's Name (First, Middle, Last)	PUF	RCHASING 18. Mot	her's Name (First		MY CONTR	ACTS
ylanı	Mental Mental arked o	To Be	DAVID		SANDLER	SARAH			LEVENTHAL
	and 2 sho leith and 127 is mu er treuma		19a. Informant's Name/Relationship (Type LEONARD SANDLER /		alling Address (Street and Num 56 MILBROOK PAI				
altimore,	Pages 1 on nent of He nent: If Item ury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	20b. Place of Dis noval from State CHIZUK	position (Name of rematory or other place)	09/18/20		TIMORE,	
Balt	permit. Departr Import eny inju		21. Signature of Funeral Service Licenses		22. Name and Address of Fac 8900 REISTERS			N & BROS KESVILLE	
	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one tmmediate Cause (Final	cause on each line.			ratory arrest,		Approximate Interval Between Onset and Death
A.	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	er's Diseas	36			
	nsit A	Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (огає в попечуванов of):	_				
8760,	ficate be executed physicien and x sthe burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):					
P.O. Box 68	The law requires thet the death certificate be executed with the been signed by the attending physicien and reasoned 2 should be detached for use as the burial-transit	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>			23d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed by should be deta	d by Ph	Part II. Other significant conditions control Diabetes Mell		a underlying cause given in Par	11. 23	3e. Did tobacco		o the cause of death?
Division of Vital Records,		omplet					la. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
/ita	ıysicien: Th iis certificete director, pag	Be (	25. Was case referred to medical examiner?			ce of Death (Chec			
<b>J</b> o	S 5	<u>1</u>	1 Yes 2 No	spitat: 1 Inpatient 2 ER/Outpat  28a. Date of Injury 28b. Time		Nursing Home 5	Residence		cify)
ion	Attending or death. ector: After by the funer	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) tniur			ascribe now and	ny occurred	
Divis	i i it o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At home, farm, building, etc. (Specify)	street, factory, office		cation (Street a ly or Town, Stat		ural Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	edical	29a. Certifier (Check only one)	cian: To the best of my knowledge, de ir: On the basis of examination and/or and manner stated.	eath occurred at the time, date a investigation, in my opinion, de	and place, and du eath occurred at the	e to the cause(s	and manner as d place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0 = 1	29c. License number			ate signed (Mont	
			Daren L. B		D3028(	046	1507	tembes	16,2006
_	3		30. Name and address of person who com	pleted cause of death (ttem 23a) (Type Main _	street, suite	200, 80	isterst	own, r	10 21136
	Sta Registr		SEP 1 9 2	32. Redistrar's Signature	parte				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 14 2 Date of Death SENTEMBER 15 HYLLIS J. STEINHORN 2006 1:15 AM **Physician** /Medical 4b. City, Town, or Location of Death RANDALLS TOWN 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CENTER BALTIMORE HOSPITAL NORTHWEST If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 213-26-0657 Director 04/16/1929 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r then "naturel", or iteme 23s or 28e-f ehow the Medical Examiner must be notified at MD N/A BALTIMORE 1 Y Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 CLARKS LANE APT. 328 21215 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Il Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify WHITE Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Deperment of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, £13 <u>DDC8</u>. RECEPTIONIST BEAUTY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY ၉ FANNYE STRAUSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK BROWN / SON 2 BAY CLUB DRIVE #16 W - BAYSIDE, NY 11360 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANSHE ÉMUNAH AITZ<sub>HAIM</sub> 09/18/2006 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Matt Cours 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE. 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No page 2 rmed? 2 K No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other. 4 Nursing Home 5 Residence 6 Other (Specify) this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours efter death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 A Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier HYSICIAN 29b. Signature and title NORTHWITT LIOSPIT AL completed cause of death (Item 23a) (Type, Print) HARISH. VVERAHALLI COURT ROAD 5401 OLD 31. Date filed (Month, 32. Aegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of	lealth and M <i>Death</i>	1ental Hy	giene ,	2006	2966
	Physici	an	1. Decedent's Name (First, Middle, Las	•			G !!!	2. Date of D Month		Year	3. Time of Death
	/Medic		Gwendolyn		Bernice		Smith	08	02	2006	17:50 M
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. C	ounty of Death	
	Funeral		Sinai Hospital  5. Social Security Number 6. Se		(In yrs. last birthday)			8. Date of B	irth		place (State or Foreign
	Director		215-78-2901	TM XTE	49 Yrs.	Months Days	Hours Min.	(Month, D	09 5	57 Coui	MD
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	vention					10d Inside Charling
	faryla •hov	ō	MD NA		Baltim						10d. Inside City Limits 1X Yes 2 ☐ No
	28a-1	rect	10e. Street and Number		Bartin	10f. Zip Code			10g Citize	en of What Cour	
	3a or	0	4504 Kathland A	ve			1207		J. 2	U.S.A	•
	death	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or N	0- 14	. Race - Americ	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Iteme 23a or 28a-1 ehow eumatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	0	1 ☐ Yes X☐ No	Specify:	nican, etc.)	s	Black, White,	lack
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au	d be ental	To Be	Samuel Alfred J	ackson			Gwendo]				
Maryland	s 1 and 2 should if Heelth and Men item 27 is marke other treumatic.	ř	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Rura				Code)
	12 g g		Ilisha Smith-Da	ughter	4504	Kathla	nd Ave,	Balti	more	, Md	21207
Baltimore,	es 1 a of Hee fitem rothe		20a. Method of Disposition	Damoual from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	(8)	Date	20c. Loca	tion - City or To	own, State
Ĕ	permit. Pages Department of Important: If it eny injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metro Cr	ematory	Inc 8/5	5/06	Balt	timore	, Md
<u>ğ</u>	ermit. epart nport ny Inj		21 Signature of Funeral Service Licen	500	M	Name and Address	ss of Facility H West				
	0 □ = 0	1	yourull C.	prug v			ash Ave,			e, Md	21215
Ę			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line	ine death. Do not ent e.	er the mode of dyin	ig, such as cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Atheros Due to (or as a	consequence of):	Cardio	vascula	DISE	ease		
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ğ	w require been sig should b	ed t	Cardiomyopathy					1 🗆	Yes 2	No 3□ Prob	ably 4 Unknown
Hecords,	as be	Completed	Morbid Obesity					24a. Was		24b. Were autop	psy findings available apletion of cause of
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or Vital	Physician: r this certifica ral director.	Be	25. Was case referred to medical examiner?	Llagaitat.		104	26. Place of Death	Check only	опе)		
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Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, farm, stre			28f. Location (	Street and N	Number or Rura	I Route Number,
É	s afte	Certification;	4 Homicide	building, etc.	(Specify)			City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Att	cal	29a. Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner stat	examination and/or inv	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurr	and due to the ed at the time.	cause(s) and plant	nd manner as st ace, and due to	ated. the cause(s)
	To the within To the Comp	Med	29b. Signature and title of certifier			29c. License	e number	T	29d. Date s	signed (Month, I	Day, Year)
	4		Thurs			D30	408		8/3	/2006	
	5		30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type,	Print)					
	)		Reed D. Winston	MD, 260	0 Libert	y Heigh	ts Ave,	Balto	, Md	21217	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	's Signature	w .					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2006

1 - For State Registrar 29670 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Diana Ethel Stamatakos September 18, 2006 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖸 F Yrs Director 198-30-7372 1937 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits or than "natural", or itama 23a or 28a-f show the Medical Expenies must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 Whitfield Road 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 StNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home Peges 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental ! Peter Passas Ethel Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Pierre S. Stamatakos Husband 323 Whitfield Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. Greek Orthodox Cem. 4 ☐ Donation 5 ☐ Other (Specify) Windsor Mill, MD 9/21/2006 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonysille, 23a. Part 1. Enter the disease or complications that caused the shock, or heart failure / List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) amplicasons myslona mour **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical use as the Phy. ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has b irector, page 2 s autonsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital Attanding Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No eral Director; After this certific filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice Certification: To 27. Manner of Peath 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours e To the Funeral D To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29c License number 58303 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 18 2000 who completed cause of death (Item 23a) (Type, Print) of BAMMO ND 2(204) Agron Charles up 31. Date filed (Month, Day, Year) 32. gistrar's Signature State SEP 1 9 2006 Registrar

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Registrar

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2006

			For State Registrar	State of Ma	aryland		rtment tificate			nd M		giene 2	006	298	572
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-	Examin	er	4a. Facility Name (If not institution, give st	tal Con	AER	st birthday)	4b. City,	of the	Location of	Ç	O. Date of Birth		n/a		
<b>V</b> .	Funeral Director				75	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Oct. 26	, 1930	) Mar	place (State of ntry) yland	roreign
	Maryland a-f ehow	tor	10a. State 10b. County  Maryland n/a		10c. City,	Town or Lo	cation imore							10d. Inside Cit 1 🛣 Yes	
	th with the 23a or 28s	ai Director	10e. Street and Number 113 E. Gittings Str	reet			10f. Zip		1230		L L	_	n of What Cou	•	
036	ours after dea ral', or itema Examiner mu	by Funerai		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		li li	Vas Deced Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- lican, etc.)		. Race - Ameri Black, White pecify: Whi	etc.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23s or 28s-f show any njury or other traumatic event, I'm Medical Examinar must be notified at another.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10 years	ation completed) College (1-4or 5 n/a	+)	life. L	lent's Usua kind of wor DO NOT us uck D	k done di e retired)	uring most	of workin	g		of Business/Ir		
yland	ould be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Charles Talbott								(First, Middle, Becker		umame)		
, Mar	and 2 sh lealth and m 27 le m		19a. Informant's Name/Relationship (Typ Gloria Talbott (wi		100	113 E	. Git	ting		Ba1	timore,	, MD :	21230		
timore	Pages 1 tment of H tant: If ite jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Cer	ace of Dispos metery, crem n Have	n Mem	her place 1. Pa	rk   9	-19-	2006	Glen 1	tion - City or T Burnie,		and
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<u>α</u>	uires that the de	Ď	Part II. Other significant conditions cont	11 1	it not result	ting in the un	iderlying ca	iuse giver	n in Part I.			bacco use	contribute to t		eath?
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	cien: To the best of er: On the basis of and manner sta	examination	eledge, death on and/or inv	estigation,	in my opi	nion, death	place, ar occurre	d at the time, d	ate and pla	ace, and due to	the cause(s)	
)	witi To	4	29b. Signature and the of certifier	2.				License PES		)			igned (Month,		26
	2		20 Name and address of person who com Lowel Garces	· Hores	V12	23a) (Type, F	Fint)	30	10/-	Sav	K Ha	ROVE	n ST.	Bakhu	art. M
	Sta Registr		31. Date filed (Month, Qay, Year) SFP 1 9 2006	32 Registra	rs Signatu	We Service	usa)								

06-06805 Charles E. Trent

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Maryland / Department of Health and Mental Hygiene

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Physicia Medical Examin		1 Decedent's Name (First, Middle CHARLES	E.		TRENT JE	?		2 Date of Deat Month Septembe		3. Time of Death 1441 hrs
/ Lydnini		4a Facility Name (if not institution				b. City, Town, c	or Location of		4c. County of Dear	
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Funeral Director		220-11-1523	7. Ag	e (In yrs. lasi		If Under 1 Ye Months Da		Min. June 5,	th(MM/DD/YYYY) 9 B 1973 Fore C	
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eath wi	Funeral	11. Marital Status  1 Never Married 2 Mar	ried 12. Was Decedent	?				n? ( Specify Yes or No Puerto Rican, etc )	14. Race - Ame White, etc.	rican Indian, Black,
after de	힣	3 Widowed 4 Divo	1 Yes 2  If Yes, Give Year or Dates.	X No	1	Yes 2 N	o specify		Specify Whi	te
hours a		15. Decedent's Education (Speci	y only highest grade cor			s Usual Occup- st of working lif		nd of work done se retired)	16b Kind of Business	/Industry
36 nin 72 than " dical l	let let	Elementary/Secondary (0-12)	College (1-4 or	5+)	Carper	nter			Private	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	17 Father's Name (First, Middle, L	ast)				18 Mother's	Name (First, Middle, M		
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Baltimore, permit Pages I ar Department of Hee Important: If iten injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other Spe		acc	matory or other mbia Men		9	9/15/2006	Columbia	
altir mit F partme portal	ł	21. Ignat re o Funeral Service L	censee		22. Na	ame and Addres	ss of Facility			
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Physician /Medical	Į	failure. List only one cause of	n each line.						est, snock, or neart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, within 24 hours after death Physician: The law requires that the death certificate be executed to the Funeral Director: After this certificate has been signed by the attending physician and Ecompletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE:	23c. If yes, outco	em#23a, me of pregna	2/,penyle	,g860, I	0/20/06		item#1, perME	y
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Box 68 e death certiff the attending ed for use as 1	Physician	1 Yes 2 No 9 Unkr		time of wood	5 Oth	er (Specify)				
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Division of To the Hospital or Attending Plumin 24 hours after death To the Funeral Director: After Peoppletely filled in by the funeral	Medical		iner: On the basis of exa							
FEFE	Me	29b Signature and title of certifier	and marmer stated			29c. Licer	se number		29d Date signed (Mo	onth, Day, Year)
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M		30 Name and address of person v Margarita Korell MD.	ho completed cause of a			enn Street, E	Baltimore	MD 21201		
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			For Stete Registrar		State	of Maryla	and / Dep <i>Ce</i>	artment of rtificate o	Health and I f Death	Mental Hy	giene 20	106	29674
	Physicia		1. Decedent's Name (Firs	rst, Middle, La	Jose	eph	Robert	Tuma		2. Date of De. Month Septer	Day Day	Year 2006	3. Time of Death 11:45PM
1	/Medic Examin		4a. Facility Name (If not i	institution, giv	re street and n	umber)		4b. City, Town	, or Location of Deat		4c. County		
	F		Annapolitar		sted Li		rs. last birthday	If Under 1 Yea	apolis ar   If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	ndel Co.
	Funeral Director		218-09-513	9	<b>X</b> M 2□ F	86	Yrs.	Months Day	s Hours Min.	Dec. 8		Mary	yland
	land ow		Usual Residence of Dece 10a. State 10b	edent c. County		10c.	City, Town or L	ocation				1	0d. Inside City Limits
	Mary B-f eho	tor	Maryland	Anne	Arundel			Anna	apolis				XXYes 2 □ No
	or 28	Director	10e. Street and Number					10f. Zip Code			10g. Citizen ol \		•
	ns 23s	Funerai	1103 Litt	le Mag		Lew cedent Ever in	I U.S.   13.		L409 f Hispanic Origin? (S	Specify Yes or No	United	Stat	
39	urs efter o al', or Iten	2	1 ☐ Never Married :	_	Armed F	forces? 2 ∐ No live tatta	ZI	If Yes, specify Cu 1 ☐ Yes 2/12/N	uban, Mexican, Puerl	to Rican, etc.)	Specify	ck, White, o y: V	etc. White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show entry figury or other traumatic event, the Medical Examinal must be notified at ODGs.	Completed	15. I (Specify on Elementary/Secondary	1	ade completed	(1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of wo	rking	16b. Kind of B		
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N N	shoute nd Me n mark umatic	၉	James F.  19a. Informant's Name/F		(Type, Print)		19b. Mail	ing Address (Stre		-	er, City or Town,	State, Zip	Code) 21409
Ž,	and 2 ealth a m 27 is		Mrs. Barbar		ran (Da				e Magothy				
Baltimore,	Pages 1 nent of H ant: If ite ury or oth		20a. Method of Disposition  1  Burial 2  Tre 4  Donation 5	emation 3 [		n State	cemetery, cre	osition (Name of matory or other p Service	Corp 9/1	Date 15/2006	20c. Location	•	aryland
Balt	permit. Depertr Importa eny inje		21. Signatur vof uneral	Il Service Lice	nsee	(			tress of Facility k Funeral e Ave. Du				
			23a. Part1. Enter the dis shock, or heart fail	ise se, or con	nofications that	caused the de	eath. Do not en	ter the mode of d	lying, such as cardia	c or respiratory a	rrest.		Approximate Interval Between Onset and Leath
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	quires thet in signed by	b	Part II. Other significant	t conditions	contributing to	death but not	resulting in the (	underlying cause	given in Part I.		obacco use con Yes 2 No	tribute to th	ne cause of death?
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Division of	or Attendent fler deat Director: in by the	Certification:	Ž ☐ Accident 3 ☐ Suicide 6 [ 4 ☐ Homicide	Could not determined	be 28e. Plac	ce of Injury - A ding, etc. (Spe	t home, farm, s	treet, lactory, office		28I. Location (. City or Ton		ber or Rura	al Route Number,
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	$\mathcal{U}_{\mathcal{M}}$		30. Name and address of MICHAEL	of person	completed a	use of death (	Item 23a) (Type		ENSE H	IGHWA	ty AN.	NAPOL	4 2006 LIS MOZIYOI
	Sta Registi		31. Date filed (Month, D.	Day, Year) 0 1 9 20	106	Registrar's Si	gnature	arli					

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Division		Decedent's Name (First, Middle	e, Last)							2. Date of De	ath Day	Year	3. Time of Death
Physici /Medic		Leslie Wayne Um	phlett							Septemb			
Examin		4a. Facility Name (If not institution	n, give street and no	umber)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Dea	ath
		Stella Maris Ho		T		L		nium	0411				e County
Funeral		5. Social Security Number 217-56-7850	6. Sex 12⊠M 2 ☐ F	7. Age (In yrs. 55	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Da			rthplace (State or Foreign ountry)
Director		Usual Residence of Decedent		33						March (	11,19	oT Bal	timore,MD
yland		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits
Mar.	ţ	Maryland Balti	more Cour	nty Up	perco								1 ☐ Yes 2Ž <b>∑</b> NŠlo
with the Maryland s or 28a-f show	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What C	ountry?
filed within 72 hours after death with the Maryland Hygiene. other then "natural", or Itama 23a or 28a-f ahow ant, the Medical Examinan must be notified at		17320 Falls Roa	d				21	155			Unite	ed Sta	tes
r deg	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe 1, Puerto	cify Yes or No- Rican, etc.)	- 14	. Race - Am Black, Whi	erican Indian, ite, etc.
s afte	by Fi	1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes, G	2 □XNo live		1 🗆 Yes	2 <b>X</b> No	Specity:			S	pecify:	White
hour tural		15. Deceden	Year or	Dates:	16a. Dece	dont's Heur	J Occupa	ation			16h King	of Business	
in 72 an r	Completed	(Specify only highes	st grade completed		(Give	kind of wo	rk done d	turing mos.	t of worki	ng	TOD. KING	I OI DUSIIIESS	whicustry
d withir giene. rr than	E	Elementary/Secondary (0-12)	College n/a	(1-4or 5+) L		Truck					Stat	te Hig	hway Admins.
illed Hyg othe	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	Maiden S	umame)	
Alenta Alenta rked tic ex	To B	Albert Lee Umph	lett					Marg	sie V	irginia	Bliz	zzard	
ages 1 and 2 should be filed within ant of Health and Mental Hygiene. At: If Item 27 is marked other than y or other traumatic event, the Me		19a. Informant's Name/Relations								l Route Numbe			
and and a saith		Mrs.Nancy Lou(n	ee Runyec			7320		s Roa	ıa 	Upperco	, Mary	yrand	21155
of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 DRemoval from	State	Place of Dispo cemetery, crei	matory or o	ther plac			ate		•	r Town, State
permit. Pages Department of I Important: If It any injury or o 2002.		4 Donation 5 Other (S		Ev	ans Fu	neral	Cha	pel  S	ept.	19,200	For	rest H	ill,Maryland
pparti port ny inj		21. Signature of Funeral Service	Licensee	' an	4 - D	2. Name an	d Addres	s of Facilit	y vətti ta	oc Func	v=150	romat	ion Ctr D 7
205 2 9		1 - 10 he	y T	. 9/00	2	325 Y	ork	Road	Ti	monium,	Mary	land	ion Ctr.,P.A 21093
		23a. Fart1 Enter he di ease, or share, or he art failure. List	of plications that no one cause on	caus of the dea each line.	th. Do not ent	ter the mod	e of dyine	g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	a LUI	NG CANCE	ER								Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):								
Examine	lu.	Sequentially list conditions, if any, leading to immediate	b										
ed sit	Examiner	cause. Enter underlying Cause (Disease or injury	Dugic	(or as a consec	querice or):								
be executed sicien and burial-transit	хап	that initiated events resulting in death) Last	c	(or as a consec	quence of):								
sicier buris	calE		4										
ificate p physics the	edic		U.							_	-		
n certific anding p use as:	clan/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Je					23	d. Date of de	livery
dealt	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	birth 2 Teta nant at time of c		]Ectopic pr ] Other (sp						Month	Day Year
t the de by the tached	hysi	9 Unknown	9□ Unki	nown									
The law requires thet the death certific tie has been signed by the attending p bage 2 should be detached for use as:	by P	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use	contribute t	o the cause of death?
v require been sig should b										101	'es 2□	No 3∏P	robably 4XUnknown
aw re	plet									24a. Was		24b. Were a	utopsy findings available completion of cause of
The I	Completed										med?	death?	·
ian: ortifica ctor,	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
Attending Physician: r death. metor: After this certific by the funeral director.	2	1 ☐ Yes 2 X No	Hospital: 1	Inpatient 2	] ER/Outpatier	nt 3 DC	A Othe	ar: 4 □ Nu	rsing Hor	me 5 ☐ Resid	lence 6]	Other (Spe	ecify) HOSPICE
ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date (Mo	of Injury oth, Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at		28d. Describe h	ow injury	occurred	
tendi death. tor; A the fu	catl	2 Accident investi	gation			М		/es 2 □ I					
or Att	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 289. Place	e of Injury - At h ding, etc. (Speci	nome, farm, str ify)	eet, lactory	, office		1	28f. Location (5 City or Tox	itreet and i m, State)	Vu <i>mb</i> er or A	lural Route Number,
a Hospital or Attendi 24 hours after death. • Funaral Director: A etely filled in by the to													-44
Hospital 24 hours a Funaral ( tely filled	edical	29a. Certifier 1 Certifyir (Check only one) 1 Medical	g Physician: To the Examiner: On the	basis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim in my op	e, date an pinion, dea	d place, a th occurr	and due to the o ed at the time, o	ause(s) ar date and p	nd manner a lace, and du	s stated. e to the cause(s)
To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifie		nner stated.		290	License	number			29d Date	signed (Mog	th, Day, Year)
7 × 5 8		and the state of state of	:1=			-		372	-		Date	9110	/x /
O.		20 Name and address of	uho complete i	ion of death the	m 03c) (** :	,		7/2	-2			418/	00
D		30. Name and address of person  TARIO MAI		O DULAN			RD	ттмоч	ITIM	MD 210	103		
Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Sign	atura 11		ıπ.	TITO	TUIT,	rw ZI(	173		
Registr		SEP 1 9	2006	245 A	5. 200	wie							

Division of Vital Records, P.O. Box 68760,

WAYNE UMPHLETT

SEPTEMBER 17, 2006 10:10 p.m.

Baltimore, Maryland 21215-0036

		1	For State Registrar	State o	f Maryla		artment rtificate			d Mental Hy	giene	2006	298	576
. 0	Physicia	e an	1. Decedent's Name (First, Middle,							2. Date of De Month	Day	200C	3. Time of	
13	/Medic	al	Jason Matthew Unda. Facility Name (If not institution,		nher)		4h City To	own orl	ocation of D	September		2006 County of Death	3:15	Ам
400	Examin	er	107 Aspen Wood Way	-	11001)		,	Roseda	_			Baltimor		
	Funeral Director		5. Social Security Number 218-19-9699	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs 22	s. last birthday) Yrs.	Il Under 1 Months	Year Days	Hours N	Hrs. 8. Date of Bir Min. (Month, Da 05/21/1	th ay, Year) 984	Cou	place (State of intry) land	Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	ocation						10d. Inside Cit	y Limits
	Mary Hed	tor	Maryland I	Baltimore		R	osedale						1 🗆 Yes	2 <b>▼</b> No
	th with the 23a or 28 ist be not	ai Director	10e. Street and Number 107 Aspen Wood Way	Apt. G			10f. Zip C	237			_	en of What Cou S.A.	intry?	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "naturel", or Items 23a or 28a-f show event, the Medical Examinat matter notified at	by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 No		Was Decede If Yes, specif	y Cuban,	panic Origin , Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)		4. Race - Amer Black, White Specify: Wh		
5-0	"natur	Completed	15. Decedent' (Specify only highest			(Give	dent's Usual kind of work DO NOT use	done du	ion iring most of	working	16b. Kin	d of Business/h	ndustry	
121	within iene. than "	dmo	Elementary/Secondary (0-12)	College (	I-4or 5+)		1 Mechan				Truc	king Indu	stry	
n	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, L					1		Name (First, Middle		Sumame)	_	
yla	ould be d Mental narked o	P.	James Franklin Uhl			19b Maili	na Addross /	Street ar		May Randal		Town State 7	in Code)	
	s 1 and 2 should f Health and Mer Item 27 is marks other traumatic		James Franklin Uhl				•			timore, Mary			p 0000)	
Baltimore,	00		20a. Method of Disposition  1   → Burial 2   □ Cremation  4 □ Donation 5 □ Other (Sp.		State	Place of Dispo cemetery, cre eland Me	matory or oth	er place,		Date 19–2006		more, Mar		
Balti	permit. Page Department Importsnt: If eny injury o		21. Signature of Funeral Service L	icensee Charl	es Miner		2. Name and onard J			5305 Har Baltimore		oad yland 212	14	
	ži.		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	aused the de	)		1		1 1	rrest,		Approximate Interval Bett Onset and I	ween ?
8.	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	b	(or as a conse	equence of	nshó	Tu	sounc	to he	ad		5 minu	tes
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	(or as a consections of pregonth 2 ☐ February at time of	nancy stel death 3(	□Ectopic pre				2	23d. Date of deli Month		/ ear
o.	that the de led by the a detached t	nysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unkr		i death St	_ Other (spe	City)						
rds, P	quires that n signed b ald be deta	by	Part II. Other significant condition	ns contributing to d	eath but not r	esulting in the t	underlying ca	use giv <i>e</i> r	n in Part I.		tobacco u Yes 2	se contribute to □No 3□Pro	1	leath? Inknown
Records,	The law requir ate has been s page 2 should	Completed								24a. Wa: auto perf 1  Yes		24b. Were au prior to death?	topsy findings completion of c	available ause of
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	r	Death (Check only				
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: Aller this completely filled in by the funeral di	Medical Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	28a. Date (Mor ation Septem	of Injury oth, Day Year)	6 6315 home, farm, st	of 28	lc. Injury Work' 1   Y	at ?	28d. Describe	how injun	occurred   hot wa	und per per le	
	Hospits     24 hours     Funeral	dicai	29a. Certifier (Check only one)  1 Certifyin 2 Medical	Examiner: On the t	e best of my k pasis of exami nner stated.	nowledge, dea ination and/or ii	th occurred a nvestigation,	it the time in my opi	e, date and p inion, death	place, and due to the occurred at the time	causers) , date and	and manner as place, and due	stated. to the cause(s	;)
	To th withir. To th	Me	29b. Signature and Mile of certifier	de	Des	ytu		License				e signed (Mont) tembe		×6
	6	<	Philip Milite	SEM, OY	Trim	ple H	Print)	Lu	theru	alle, M	q' 5	1093	3	
	Regist		31. Date filed (Month, Day, Year)		Registrar's Sig	gnature	frank i	-						III -
UF	IMH 17 Rev 1/2	2001	- T			ORIGI	NAL							

		1- For State of Maryland / Dep Registrer Co	ertificate of Death	Mental Hygiene 2	006 29677
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	sician	Olive Kruhm Underwood		September 17,	2006 9:25 P. M
	dical miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		nty of Death
		Carroll Hospital Center	Westminster	Carr	o11
Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	/) If Under 1 Year If Under 24 Hrs Months Days Hours Min		Birthplace (State or Foreign Country)
Direct		216-05-2315 1□ M 2XF 96 Yrs.		August 25,1910	Maryland
pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
aryla •ho	7				1 ☐ Yes 2 ₩ No
death with the Maryland ms 23a or 28a-f ehow must be notitied at	Director	10e. Street and Number	10f. Zip Code	10g Citizen	of What Country?
with	ă				
eath	erai	713 Midway Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13	21771  . Was Decedent of Hispanic Origin? (		tates of America
fter d	Funerai	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 2 No	if Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	llack, White, etc.
urs a	ğ	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 <b>x</b> No Specity:	Spe	cify: White
72 hours insture!, o	Completed	15. Decedent's Education (Specify only highest grade completed) (Gi	edent's Usual Occupation	16b. Kind of	Business/Industry
thin 7	pie	Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)		
A maignant	5	_ 2 BOO	k Keeper		ruction
Ta se file	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Sum	ame)
VIBING Suld be file Mental Hy arked oth	ျှ	Edward George Kruhm	Mary P		
Mar d 2 sho th and t7 1 mu	9 46 3		ling Address (Street and Number or R		
and and ealth m 27			l Damascus Road,		
of Hilliam		20a. Method of Disposition 1 SyrBurial 2 Cremation 3 Removal from State 20b. Place of Discemetery, co	ematory or other place)	Date 20c. Location	n - City or Town, State
altimore, mit. Pages 1 ar partment of Hea portent: If Item y Injury or othe		4 ☐Donation 5 ☐ Other (Specify) Mount Vi			ttsville, MD21104
BAITIMOFE, MARYIANG ZIZIS-UU3O permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importments if Item 27 ie marked other then "naturel; or Items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examinating notified all	ğ			-	eral Directors,In
<b>n</b> &&£5	a		3728 Liberty Road,		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition	ON PNEIL	MONIA	48HR5
/Medic Examin		resulting in death)  Due to (or as a consequence of):			
LAGITIT		Ecquentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
ed sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
xecul and Il-trar	xan	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):			
8 / 6U, cate be executed physicien and the burial-transit	<u>e</u>				
DX/ icate phys	dicai	d.			
that the death certified by the attending detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d.	Date of delivery
BOX eath cerr attendin Ifor use	ciar	23b. Was decedent pregnant in the past 12 months?  1	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
She the Control	ysi	1  Yes 2 No 9 Unknown 9 Unknown		eago — — — — —	
Hecords, P.O. Box of The law requires that the death certif we has been signed by the attending age 2 shruld be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use c	ontribute to the cause of death?
HECOLDS, he law requires I e as been signe	by by	HYPOTENSION		1 □ Yes 25 No	3 ☐ Probably 4 ☐Unknown
w require	Completed	PANGEGINE NEDO	T ENIL VIR	24a. Was an 24	b. Were autopsy findings available
The lav	E G	· CONCEDIVE ACTION,	JTIL GIVE	penormed?	b. Were autopsy findings available prior to completion of cause of death?
	ပိ		OC Bloom of Do	1 ☐ Yes 2 ☐ No eath <i>Check only one</i>	1 ☐ Yes 2 ☐ No
VITA sician: certific lirector,	0 0	examiner?	Other	Home 5 ☐ Residence 6 ☐	Other (Spacify)
Of Phys or this oral dis			of 28c. Injury at	28d. Describe how injury oc	
On ding lath.	ş	1) Anatural 5 Pending (Month, Day Year) Injur	Work? M 1 □ Yes 2 □ No		
DIVISION OT VITA  I or Attending Physician: after death. Director: After this certific in by the funeral director,	الله الله	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		mber or Rural Route Number,
s after C	Certification:	4 Homicide building, etc. (Specify)		City or Town, State)	
DIVISIO  To the Hospitel or Attend within 24 hours after death To the Funerel Director:  Completely filled in by the f	ië O		ath occurred at the time, date and place	ce, and due to the cause(s) and	manner as stated.
he Hi in 24 he Fi	edicai	(Check only one)  [ Medical Examiner: On the major is of examination and/or and manner stated.	mivestigation, in my opinion, death occ	Juneo at the time, cate and place	e, and due to the cause(s)
To the	Σ	29b. Signature and titl, of certifier	29c. License number	29d. Date/sig	ned (Month, Day, Year)
		1 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	12505	2 9/1	8106
1/2		30. Name and a ress of person who completed cause of death (Item 23a) (Typ	e, Print) SUITE 102	own	75 MD
12		HAIEEZ A SYED, 20 0	ROSSROPES 3	DR. MILLS	3 21/17
	State	31. Date filed (Month, Day, Year) SFP 1 9 2006 32. Registrar's Signature	parti		
Hea	istrar	DEL T O FOOD MANAGEMENT			

			For State Ragistrar	State of Ma	aryland /	Depa <i>Cer</i>	rtment of F tificate of	lealth a <i>Death</i>	and Me	ntal Hygi	ene 2 (	006	2967	18
	Dhyoisi		Decedent's Name (First, Middle, L.)							. Date of Death Month		Year	3. Time of Death	1
	Physici /Medio			Willi	illiams				Septembe	r 17,	2006	5:00 A	М	
ı	Examin	er	4a. Facility Name (If not institution, g.		Nov. Linda of Death				y of Death					
	Funeral		3243 Atlee Ridge 5. Social Security Number 6.	Sex 7. Ag	New Windsor  If Under 1 Year   If Under 24 Hrs.			Date of Birth		Carroll  9. Birthplace (State or Fore Country)		ign		
	Director		206-26-6599 1X M 2 F 72 Yrs. Months Days					Hours	Min.	Month, Day, UG 23,	1934	Penns	ylvania _	
	yland Iow		Usual Residence of Decedent  10a. State 10b. County	cation 10d. Inside City Limits						its				
	e Man	ctor	Maryland Carroll New Windsor						1 □ Yes 2X				10	
	with th	Directo	10e. Street and Number	D 1			10f. Zip Code			10	g. Citizen of	Citizen of What Country?		
	ns 234	Funeral	3243 Atlee Ridg	12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		13. V	Vas Decedent of H		776 igin? (Specif	v Yes or No-		USA 14. Race - American Indian,		
٥	ours after death with the Marylan rai', or items 23e or 28a-f show Exercities in that be inclifted at		1 ☐ Never Married 2 💢 Married			a U.S. 13. Was Decedent of Hispanic Origin Yes, specify Cuban, Mexican,  1 ☐ Yes 2 ☑ No Specify:					1	Black, White, etc.  Specify: White		
2-0036	72 hours after death with the Maryland natural; or items 23s or 28s-f show disal Exaculational be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's I	Year or Dates:	Year or Dates: 1952-55		6a. Decedent's Usual Occupation							
212	within 72 ho ene. than "natur ire Medical	Completed	(Specify only highest g	rade completed)  College (1-4or 5		(Give I	Give kind of work done during most of workir life. DO NOT use retired)		st of working	"	bo. Kina of E	. Kind of Business/Industry		
_	filed with Hygiene other the	Com		4 Man			agement Troubleshoot					ederal Government		
and	be de la	9 Be	17. Father's Name (First, Middle, Last)  Robert Bailey Williams  18. Mother's Name (First, Middle, Last)  Florence 1							Elda Findley				
Maryland 2	s 1 and 2 should f Health and Men Item 27 is marke other traumatic	To	19a. Informant's Name/Relationship		1:	9b. Mailin	g Address (Street					,	Code)	
	and 2 ealth a n 27 is		Nancy K. Willian	ns/Wife		3243	Atlee Ri	de F	Road					
ore			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		ceme	tery, crem	sition (Name of atory or other place	· 1	Date		oc. Location			
altımore,	permit. Page Depertment of Important: If sny injury or once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Metro	Cre	matory,	Inc.	9/18/0	06	Baltin	ore,	MD Tona	_
ñ	Permi		21. Signature of Funeral Service Licensee (22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228											
	mysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Control Ports.											
			Immediate Cause (Final disease or condition resulting in death)	a prostate cancer 11 mon								1 month	S	
				b.  Due to (or as a consequence of):  c										
	is played	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
	and and litrans	Examin	Cause (Disease or injury that initiated events resulting in death) Last											
	certificate be executed adding physicien and as as the burial-transit	edical E		d										
_	artificating physes as the	Medi	IF FEMALE:								1			
X Q Q	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	33c. If yes, outcome of pregnancy   1							23d. Date of delivery Month Day Year		
r Ö	t the da by the ached	hysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown										
	wrequires that the de been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						l.		3e. Did tobacco use contribute to the cause of death			
0.0	requir	eted											ably 4 Unknow	
e L	e la hes	Completed								24a. Was an autopsy performe	ed	death?	sy findings availab apletion of cause of	le f
T VITA	sician: Th certificete rector, pag	a	25. Was case referred to medical					26. Place	e of Death	1 Yes 2 Check only one		1 🗆 Yes	2 No	
	d is	To B	Avaminer?  1							ome 5 V esidence 6 Other (Specify)				
	ding P h. After I funera	Certification;								28d. Describe how injury occurred				
	To the Hospital or Attanding PP within 24 hours attended. To the Funeral Director: After the completely filled in by the funeral	Ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2							28f. Location (Street and Number or Rural Route Number,				
		Cert	4 ☐ Homicide determined building, etc. (Specify)								City or Town, State)			
		edical	29a. Certifier  (Check orly one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within To the comple	Me	29b. Signature and title of certifier	and mariner sta	29c. License number					29d. Date signed (Month, Day, Ye			Day, Year)	_
			Mounge	L 85A	01	M.O.	1	743	083	S	eptemb	oer 18	3, 2006	
	4		30. Name and address of person who	completed cause of d	eath (Item 23a	a) (Type, F	Print)		4	200 0	1	1	Λ	
74	Sta	te	31. Date filed (Month, Day, Year)											
	Registr		SEP 192	006	es to	See								

			1 - State of Ma	aryland / I	Departme Certifica	nt of H te of L	eaith an Death	nd Men	tal Hyg	iene g. No. 2006	29679	
	Physici	an.	Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year  3. Time of Death			
	Physici /Medic	cal	Katherine Wilbanks		4h Cih	Tour or	Location of D	0	09-15-20066:524			
	Examin	ier	4a Facility Name (If not institution, give street and nymber) Franklin Square Ho	spital	46. City	, Town, or	Location of L	Death		4c. County of Dea	more	
	Funeral	1		e (In yrs. last bi	irthday) If Under	or 1 Year Days	If Under 24 Hours	Min.	Date of Birth Month, Day,	year) 9. Bird Co. 1925 Ken	thplace (State or Foreign buntry)	
	Director		Usual Residence of Decedent					NO	v. 8,	1925 Ken		
0)	ours after death with the Maryland ral', or Itema 23s or 28s-1 show Examiner myst be notitied at	ō	10a. State 10b. County  Maryland Baltimore	10c. City, Tow	vn or Location Notti	10.0m					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
2		rect	10e. Street and Number			p Code			10	0g. Citizen of What Co	Α	
-		raiD	4415 Fieldgreen Road 21236							u.s.,		
he 036		by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent I Armed Forces?  1 Yes 2 Will I Yes, Give Year or Dates:		13. Was Deci If Yes, sp	ecify Cuba	spanic Origin n, Mexican, F Specify:	1? (Specify ` Puerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, Whit		
500		eted	15. Decedent's Education (Specify only highest grade completed)	16a	a. Decedent's Usi (Give kind of w	ork done a	luring most of	f working		16b. Kind of Business	Industry	
2121	d within piene. r then the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5	3+) B	ookkeepe		)			Used Car 1	Dealership	
[ pu	s 1 and 2 should be filed within 72 hd f Health and Mental Hygiene. Item 27 le marked other then "natu other traumatic event, the Medical	Be	17. Father's Name (First, Middle, Last)  Ira Harvey					Name (Fire		Maiden Sumame)		
25 E	2 should and Mer le marke sumatic	2	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Addres	s (Street a				City or Town, State, a	Zip Code)	
, M.	s 1 and 2. If Health at Item 27 le		Mrs. Kathy Addams (daught		415 Fiel						1236	
$\mathcal{M}_{1}$   $\mathcal{M}_{2\alpha n}$   $\mathcal{M}_{5}$	permit. Pages 1. Department of He Important: If Iten any Injury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	I	of Disposition (Na ery, crematory or		1	Date / 1 0 / 0		20c. Location - City or		
=======================================			4 Donation 5 Other (Specify Entombmen) 21. Signature of Europe Services is ansee	r vacan						ineral Homi		
Na Na	Depar Impoor		> Eli Tella		9705	Bela	ir Rd.	, Bal	timore	2, MD 21230	5	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									
			disease or condition resulting in death)  a. He ore wyocaldia the factory  Due to (or as a consequence of):									
	Examiner	16	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Diabetes Mellitus									
	cuted	Examiner										
8760,	cate be executed physicien end ; the burial-transit											
9	ificate by physical desired the base the b	edical	d								-	
Вох	death certific ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome 1 □ Live birth	2 Fetel death						23d. Date of de	livery Day Year	
P.O. I	the de yy the e ached f	hysic	1 ☐ Yes 2 D No 4 ☐ Pregnant at 9 ☐ Unknown	pecify)				_				
<u>s,</u>	The law requires that the death certifield has been signed by the ettending page 2 should be detached for use as	ð	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Pnknown			
corc	w requir been si should	leted	Ind Stage Kenal Disease					_				
Re	The lav	Completed							24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings a prior to completion of ca death?  1 Yes 2 No 2 No			
Vita	ysician: The is certificete hu director, page	Be	25. Was case referred to medical examiner?			Othe	26. Place of	Death (Ch	eck only one	9)		
of	문 = =	n: To	27. Manger of Death 28a. Date of Injury	ry 28b.		OA Injury Work	4 Nursi			nce 6 Other (Spe	cify)	
sior	tending I leath. tor: After the funer	catlo	2 Accident investigation		М	101	Yes 2 □ No					
Part II. Uther significant conditions continuiting to death but not resulting in the underlying cause given in Part I.    236. Did lobacco use continuiting to death but not resulting in the underlying cause given in Part I.    236. Did lobacco use continuiting to death but not resulting in the underlying cause given in Part I.    236. Did lobacco use continuiting to death but not resulting in the underlying cause given in Part I.    236. Did lobacco use continuiting to death but not resulting in the underlying cause given in Part I.    236. Did lobacco use continuiting to death but not resulting in the underlying cause given in Part I.    242. Was an autopsy performed by p								ıral Route Number,				
	Hoepita 4 hours Funeral	edical C	29a. Centifier  (Check only  (C									
	vithin 2 o the	Med	one) and manner sta	ated.	29	c. License	number	<u></u>	29	9d. Date signed (Mont	h. Day, Year)	
			/ fundan			Do	5334	5		9/16/06		
1	5		30. Name and address of person who completed cause of d	leath (Item 23a)	(Type, Print)	. 17.1 -	Sa	10:00	1201	10 6.11.	A- M/M 7 172°	
	Sta	ite	Dr. Thomas Krisand 31. Date filed (Month, Day, Year) 32. Registre	rar's Signature	to Pay	1711	n yy	Jave		15 Balth	nore, MO, 31237	
	Registr		CED 1 9 2006	Person L	7. 6034	1						

State of Maryland / Department of Health and Mental Hygiene 29680 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician WHITE IRMA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner COLUMBIA HOWAR D LORIEN NURSING REHAB. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 21/2 F Director 89 220-30-1923 Aug. 11, 1917 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the McClical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1327 North Point Road 21222 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Exemina-Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: 3 √Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Wilson Umstott Catherine Mae Allen ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold White 10783 McGregor Drive Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk. 9/19/06 Elkridge, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Maryland 21222 22. Name and Address of Facility 7922 Wise Avenue Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** YEARS CORDNERY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner inding physician and use as the burial-fransit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be HYPERTENSION 1 Yes 2 No 3 Probably 4 MUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDE MIA this certificate 2[] No 1 ☐ Yes 2 🛛 No 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 25 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: Alt managed by the further or the further 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053411 wheaton 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q Bonie 20715 14300 Gallow FEN LA # 210 MD Shosagni 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 SEP 1 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 2968 1 - For Stete Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John G. Williams Sept 13 2006 10:19 D /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 931 St. Paul Street Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 🛣 M 2 🗆 F 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 217-54-2741 Yrs Maryland Director Aug 26, 1947 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show or other traumatic avent, the Medical Exerciner must be notified at 1⊊Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 931 St. Paul Street 21202 U.S.A. Itams 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) Hygiene. Cook Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any injury or other traumetic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Polly Stevens Marsha Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Williams/Cousin 822 Guilford Ave Suite 142 Baltimore MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Pemoval from State \* 4 □ Donation 5 □ Other (Specity) Western Cemetery Sept 20, 2006 Baltimore MD 21. Signature of Funeral S 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, of com-shock, or heart failure. List only to not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit that initiated events resulting in death) Last P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1∏Live birth in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2100 Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No Certification: To 5 esidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To tha Hospital or Attandii within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ロ32717 7505 30. Name and address of person cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State SEP 1 9 2006 Registrar

		_	For State Registrar	State of Maryla	nd / Depa	artment o	of Health of Death		no-	y. 140,	29682
	Physicia	an	1. Decedent's Name (First, Middle, Las Carroll M.	woodcock				2	Date of Death Month 9 1	Day Yeer .5 2006	3. Time of Death 9:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tov	vn, or Location	of Death		4c. County of Dea	
			Anne Arundel Medi				polis	04)		Anne Ar	
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1. Social Security	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Y Months D	ays Hours	Min. 5	Date of Birth Month, Pay, 28 / 192	Year) 9. Bir	thplace (State or Foreign puntry)  MD
	70		Usual Residence of Decedent						, = 0, = 3 =		
	arylan show	7	MD Anne Aru		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2√√ No
	the Mi	Funeral Director	MD Anne Aru	indel	Severn	a Park	de		10	ng. Citizen of What C	
	3a or	<u>D</u>	446 Community Roa	ıd		21146				USA	,
	death	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent		rigin? (Speci		14. Race - Ame Black, Whi	
36	s after , or Ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No		1 ☐ Yes 2 <b>X</b>			,	Specify:	W
ö	ture!	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual O	ccupation		1	6b. Kind of Business	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "naturel", or Items 23a or 28e-f show apprintury or other treumatic event. It a Maries Examinar must be neitlied at 905e.	Completed	(Specify only highest gra		(Give	kind of work of DO NOT use r	etired)	st of working		Toop	ŕ
7	ed wit ygiene ner the	Соп	4			C00			5-11-1-1	FOOD	
Maryland	d be fill	Be	17. Father's Name (First, Middle, Last) unknown					unknow		faiden Sumame)	
ary.	should nd Me mark umatic	မ	19a. Informant's Name/Relationship (	Гуре, Print)	19b. Maili	ng Address (S				City or Town, State,	Zip Code)
ž	and 2 allth a n 27 le		Mrs. Deborah Simo					d, Seve	erna Pa	rk, MD 211	.46
ore	of He of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	memovaritom state	Place of Dispo cemetery, cre			Dat		20c. Location - City or	
altimore,	t. Pag rtment rtent: njury		* 4 Donation & □ Other (Specifi	() Cr	esapeal	ke Crem 2. Name and A		9/18/2		Stevensvi	lle MD
Ba	permi Depa Impo eny it		21/Signalure of Funeral Service Con		364			Sing	gleton	F.H. e MD 21061	
	_		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused a e de							Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	1	reym	•					Onset and Beeth
	/Medical Examiner		resulting in death)	Due to (or as a cons-	equence of):	,					
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J.	cuted	Examin	triat initiated events	C							
8760,	icate be executed physician and s the burial-transit	ai Ex	resulting in death) Last	Due to (or as a cons	equence of):						
687	death certificate be executed e attending physician and of for use as the burial-transit	edicai		d							
Вох	leath certific: attending pl	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		⊒Ectopic <b>preg</b> r	nancv			23d. Date of de	
O. B	that the death ed by the atte detached for	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (speci				Month	Day Year
<u>α</u>	law requires that the as been signed by th 2 should be detache	/ Ph	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	anderlying caus	se given in Part	t I.	23e. Did tob	acco use contribute t	o the cause of death?
Vital Records,	w requires t been signe should be	ed by							1 □ Ye	s 2□No 3□P	robably 4 wknown
900	ne law re has bee ge 2 sho	Completed							24a. Was an	24b. Were a	utopsy findings available completion of cause of
<u> </u>	The ate h page	Con							perform	ied? death?	-1 -12
Vita	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Other	-	Check only one		
of		F	1 Yes 2 2	28a. Date of Injury	28b. Time o		Injury at			nce 6 Other (Spe w injury occurred	icity)
ion	Attending Products of the funeral by the funeral	atio	1 Accident 5 Pending investigation		Injury	М	Work? 1 ☐ Yes 2 ☐	□No			
Division	l or Attendater deatl Director:	Certification:	3 Suicide 6 Could not b		home, farm, st cify)	reet, factory, o	ffice	28	f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	e Hospital 24 hours a e Funerel D letely filled		29a. Certifier Certifying Ph	ysician: To the byest of my k	nowledge, deat	th occurred at t	he time, date a	and place, an	d due to the ca	use(s) and manner a	s stated.
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Exar	niner: On the basis of exami and manuer stated.	ination and/or in	nvestigation, in	my opinion, de	eath occurred	at the time, da	ite and place, and du	e to the cause(s)
	To the within 2	Σ	29b. Signature and title offcertifier	/(_ /)		29c. L	icense number	494	29	Od. Date signed (Mon	th, Day, Year)
)			· Me y	Q.f		P.111	رساء،	11		1110100	- 0
	7		30. Name and address of person who	completed cause of death (II	tem 23a (Type	Print)	nucl	1 Mz	dist	Cecten	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 9 2	32. Registrar's Sig	July 6	soil					

			For Amend Items State Registrar	25,27,2	Marylan 8a, b, c,	d / Depa d <b>, e. f</b> ,	rtmen <b>per</b> tificate	icof H	ealth a Death	7715/	Oganb	/giene Reg. No.	200	16	29683
100	Physicia		1. Decedent's Name (First, Middle, I Richard B		on						2. Date of D August		′2006 <sup>۲</sup> ′	ear	3. Time of Death 8:41 ам
	/Medic Examin		4a. Facility Name (If not institution, g St. Joseph Medi					Town, or	Location of	f Death		4c.	County of Balti		<b>:</b>
	Funeral Director		5. Social Security Number 6. 217-18-5852	Sex 1 <b>X</b> M 2□F	7. Age (In yrs. I 82	ast birthday) Yrs.	If Under Months		ff Under 2 Hours	Min.	8. Date of B (Month, D	irth 2ay, Year) 1, 19	9 23 P	Birthpla Countr	ce (State or Foreign y) y) y) y) y)
	ryland how		Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo	cation							100	d. Inside City Limits
	h the Mai	Director	Md. Baltime	ore	Bal	ldwin	10f. Zip	Code				10g. Citi	izen of Wha	at Countr	1 ☐ Yes 2 🗶 No y?
	death wil	Funerai D	13614 Devonbrool	12. Was Dece	dent Ever in U.	S. 13. y	Was Deced	2101 tent of Hi	spanic Orio	gin? (Spe	cify Yes or N	10-	14. Race -		
920	2 should be filed within 72 hours after death with the Maryland and Mented Hygiene.  is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Mccleal Examiner must be neitified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 XYes If Yes, Giv Year or Da	2  No		fYes, spec 1 ☐ Yes :	-	Specify:	, Puerto I	Rican, etc.)		Specify:	White, et	ihite
Maryland 21215-0036	nin 72 hou  in "nature Medical E	Completed	15. Decedent's (Specify only highest (		-4or 5+)	16a. Deced (Give life. L	ient's Usua kind of wor DO NOT us	rk done a	uring most	of working	ng	16b. Ki	ind of Busir	ness/Indu	stry
d 212	filed with Hygiene ther the int, the		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, La			Insur	ance	Ager		r's Name	(First, Middl	e, Maiden	Insur	ance	<u>:</u>
ylanı	d is b	To Be	George M. Wills								eth C.		<u> </u>		
	りまいき		19a. Informant's Name/Relationship Mrs. Ruby M. Wil		fe		-				Baldw				Code)
lore,	Pages 1 ament of Heament: If Item		20a. Method of Disposition 1 XBurial 2 Cremation 3		State	lace of Dispo	natory or o	ther place		□ 1-8-8	ate		ocation - Cit	•	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other ODCS.		4 □Donation 5 □Other (Spe 21. Signature of Funéral Pervice Lic		Mil	l dwood	. Name an	d Addres	s of Facility	v	ral Ho			ispor	t, Pa.
<b>60</b>	89 2 2 3		23a. Part1. Enter the disease, or co	implications that c	aused the death	n. Do not ent	1050	O You	ck_Rd	. To	vson.	Md. 2	1204		Approximate
	Physician		shock, or heart tailure. List on Immediate Cause (Final disease or condition	a. Acu1	ach line.	RKBR :						1			nterval Between Onset and Death
	/Medical Examiner		resulting in death)		or as a consequence		125	AW 4	-		W				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	uence of):					1/5	/	CAL EXAMIN	ER	
8760,	ate be executed hysician and the burial-transit	I Exa	that initiated events resulting in death) Last	c	or as a consequ	uence of):				V	APPROV	Sel Hen			
9	ate hy:	edical		d						18-20 EV	21.3%				
P.O. Box	Attending Physician: The law requires that the death certifics relath. r death. ector: Atter this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as to be the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregna inth 2 Peta ant at time of down	I death 3	Ectopic pr Other (sp		0.00				23d. Date o Month		y Day Year
	uires that the signed by d be detacted	Ď	Part II. Other significant conditions	s contributing to de	eath but not res	ulting in the u	nderlying c	ause give	en in Part I.		y	tobacco u			cause of death?
Division of Vital Records,	s law requir has been si e 2 should	Completed	DIABETTO 1								24a. Wa	opsy	pric	or to com	sy findings available pletion of cause of
tal H	ysician: The lavis certificate has director, page 2	0	ACNIAL  25. Was case referred to medicat	FIBRIL	L ATTO	ر			26. Place	of Death	1 Yes	1	1 🗔	ith? Yes 2	!□ No
of <	Physici this cer al direc	To B	examiner? 1 X Yes Z X NO  27. Manner of Death	Hospital: 1 28a. Date	Inpatient 2	ER/Outpatier			4 🗆 190		ne 5 Re				
ion	auth. or: After he funer	ation	1 Natural 5 ☐ Pending investigat	(Man) 06/2	th, Day Year)	fnjury	₽M	28c. Injury Work 1 🔲 `	(?) Yes 2.0000	1		ect 1	•		
Divis	after de after de I Directo d in by ti	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place	of Injury - At hong, etc. (Specif	ome, farm, str y)	eet, factory	y, office		1.3	3614°′D	own, State <b>evon</b> i	nd Number Drook	or Rural <b>Rd</b> .	Rout <b>e</b> Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Ex	Physician: To the	best of my kno asis of examina	ition and/or in	vestigation	, in my or	pinion, deat	d place, a th occurre	ed at the time	e cause(s)	) and mann d place, and	er as sta d due to t	ted. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	replu	- mo	)	290	D 7	number	37			te signed (		ay, Year)
7-	+1/		30. Name and address of lerson with 146 00	no completed caus	se of death (Item	1 23a) (Type,	Print)	) 2	1209	+			, ,		
	Sta Registi		29b. Signature and title of certifier  30. Name and address of ferson with the control of the co	32. F	legistrar's Signa	iture	2)	-							
	1109131		SEL I O 500	Fred Contest	المحتالي المعالم	A STATE OF THE PARTY OF THE PAR	March .								

	, a		1 - For State Registrar		ryland / Depa	artment of H	lealth and M Death		Reg. No.	2006	29681
3	Physici	an	1. Decedent's Name (First, Middle, Last Barbara A.	Allen				2. Date of Dea	Day	Year	3. Time of Death
N. S.	/Medi		4a. Facility Name (If not institution, give			4h City Town or	Location of Death	August	30	2006 ounty of Death	10:10p <sup>M</sup>
Œ.	Examir	ier	6017 37th Avenue	street and mamber,		Hyattsv				ince Ge	
-	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da			place (State or Foreign ntry)
L	Director		579-58-9621	]M 2∏F	52 Yrs.	Months Days	Hours Min.	May 9.			ington, DC
	pur *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Marylia Pho	ō	,								1 (XYes 2 ☐ No
	the N	Directo	Maryland   Prince G	eorge	Hyattsvi	10f. Zip Code			10a Citize	n of What Cou	
	3a or		6017 37th Avenue			20782			USA	, or what ood	, .
	death	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.		ispanic Origin? (Spo In, Mexican, Puerto	ecify Yes or No-		. Race - Ameri	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ehow fra Mudical Exertirer must be notified at	þ	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	0	ir Yes, specify Cuba 1 ☐ Yes 21⁄2 No	Specify:	Hican, etc.)		Black, White, pecify: $ m B1$	etc. .ack
ည်	72 h	Completed	15. Decedent's Edu (Specify onfy highest grad	ication le completed)	16a. Dece	dent's Usual Occupa	ation during most of works	ina	16b. Kind	of Business/In	dustry
2	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	-) life.	DO NOT use retired	,				
N D	e filed v Il Hygie other t	ပိ	12 17. Father's Name (First, Middle, Last)		Accou	ntant Tec	chnician 18. Mother's Name				of Prisons
a	S E D	o Be	Walter Williams				Rose L		Maidell 30	imatile)	
<u></u>	2 should be and Mental ie marked aumatic ev	2	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	I Route Numbe	r. Citv or T	own, State, Zin	Code)
	d 2 th a tra		Darrell Drayton/S	on							n DC 20003
altimore,			20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac	θ)	Date	20c. Loca	tion · City or To	own, State
Ĕ	Pages nent of ent: If it ury or o		1 ☐ Burial 2X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Ft. Linco			2006	Brent	wood, M	laryland
Balt	permit. Page Department of importent: If any injury or once.		21. Signature of Funeral Sen ce Licens	Mille	- F	Name and Address Linco	ss of Facility oln, Funera ensburg Ro	al Home	ıtwoo	d. MD	20722
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused in	he death. Do not ent					,	Approximate Interval Between
,	Physician	0 )	Immediate Cause (Final disease or condition	Dehydr							Onset and Death 5 Days
	/Medical		resulting in death)	Due to (or as a	consequence of):						
	Examiner		Sequentially list conditions,	0	ancer with	Metastas	sis				1 Year
	be #is	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of).						
_	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
3	icate be executed physicien and s the burial-transit	aiE									
09/89	ificate g phy: as the	edicai		J							
X Q Q	leath certifi attending I for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		Te			230	f. Date of delive	∍ry
מ	death e atten ed for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 🖺 No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		]Ectopic pregnancy ] Other <i>(specify)</i>				Month	Day Year
7. D	w requires that the di been signed by the should be detached	Phys	9 Unknown								
Ś	res th igned	Ď	Part II. Other significant conditions con		not resulting in the u	nderlying cause give	en in Part I.				ne cause of death?
ecords,	requir	ted	Coronary Artery Transient Cerebr		•			1 ( <u>3</u> )	es 2□N	No 3 Prob	ably 4 Unknown
ပ္	e 2 st	Completed	Transient Gerebr	al ischem	La —————			24a. Was a autop	sy	prior to co	psy findings available mpletion of cause of
<u> </u>	sician: The law certificate has i irector, page 2 s		_					perfor 1 ☐ Yes		death? 1 ☐ Yes	2□ No
VII	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		Othe	26. Place of Death				
<u></u>	Phy this ald	2	1 Yes 2 No	1 L Inpatien		1 3 DOA	4   Nursing Hor	πe 5 🏝 Resid 28d. Describe h			y)
0	Attending F r death. octor: After by the funera	ertification;	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	Work	r? res 2 □ No	edd. Describe n	ow injury o	ccurred	
UNISION	Attendir death.	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm, str			28f. Location (S	treet and N	lumber or Rura	l Route Number,
5	s afte s afte el Din	Cert	4  Homicide determined	building, etc.	(Specify)			City or Tow	n, State)		
	To the Hospital or Attend within 24 hours after death To the Funerel Director: / completely filled in by the fo	dicai	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of ner: On the basis of e and manner state	my knowledge, death examination and/or in- ed.	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the c ed at the time, c	ause(s) and ate and pla	d manner as si ace, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number	Z	9d. Date s	igned (Month,	Day, Year)
			- () Her and	MD		D339	988		Augus	t 31, 2	2006
R	(4)				ath (Item 23a) (Type,						
	0		Patricia A. O'Hora		525 Belcre	est Road,	Hyattsvi	11e, MD	207	82	
1	Sta Registr		31. Date filed (Month, Day, Year) <b>SEP 0 6</b> 2006	2. Registrar	's Signature	li .					
DHI	MH 17 Boy 1/9	101		Market Commence of the Commence							

			For State Registrar	State of Maryland /	Department of H Certificate of I	lealth and Mental Death	Hygiene Reg. No	2006	29685
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  W(WAY)	F. ATT	Lins	2. Date Monti Augu	- 1		3. Time of Death
	Examir		4a. Facility Name (If not institution, give str	7. Age (In yrs. last b	war I Under 1 Year	Location of Death	4c	County of Death CECI  9. Birthp	Lace (State or Foreign
	Director		Usual Residence of Decedent	1 2□F 68	Yrs. Months Days	Hours Min. 12/1	of Birth h. Pay Year) 0/1937	Cour	VA
	se Maryla 8a-f shov	ctor	DE KENT	DOVE	wn or Location			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23s or 2	Funeral Director	10e. Street and Number 420 LAFFERTY LAN		10f. Zip Code 19901		10g. Cit	izen of What Cour SA	ntry?
920	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jisal Evar.d writtual be notified at	þ	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hi II Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, etc Specify:	or No-	14. Race - Americ Black, White, Specify: WHIT	etc.
21215-0036	within ene. then "	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12	College (1-4or 5+)	a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired FLIGHT ENGIN	furing most of working )		ind of Business/Ind	dustry
Maryland	uld be filed Mental Hygi irked other	To Be C	17. Father's Name (First, Middle, Last) RAYMOND ATKINS			18. Mother's Name (First, M MILDRED MILI		Sumame)	
	and 2 should beath and Ment n 27 is marked er traumatic e		19a. Informant's Name/Relationship (Type SHARON DANIELS/DAUC		b. Mailing Address (Street a	and Number or Rural Route N	umber, City o	r Town, State, Zip	Code)
Baltimore,	Pa Pa		20a. Method of Disposition  1 ☼Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	of Disposition (Name of ery, crematory or other place N HILLS	Date 09/05/200		ER, DELAW	
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Licensed	4-P-D		HELFENBIEN ANI ROAD, CHESTER		M FUNERA MD 21620	L HOME, PA
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complica shock, or heart lailure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):	g, such as cardiac or respirati			Approximate Interval Belween Onset and Death  men 1/h5
68760,	tificate be executed g physician and as the burial-transit	ledical Examin	resulting in death) Last	Due to (or as a consequence	of):				
P.O. Box	The law requires that the death certifi sie has been signed by the attending r sage 2 should be detached for use as	Physician/M	IF FEMALE: 23c Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	ry Day Year
	w requires that the de been signed by the s should be detached	Completed by Pi	Part II. Other significant conditions contri Transferd isch	outing to death but not resulting			Did tobacco u	se contribute to th	e cause of death? ably 4 Unknown
tal Rec	sician: The law certificate has t rector, page 2 s	e Comple	25. Was case referred to medical			1 D Y	Was an autopsy performed?	24b. Were autop prior to con death? 1 ☐ Yes	osy findings available appletion of cause of
of Vi	Physicia this cert al direct	ToB	examiner? 1 ☐ Yes 2 ☐ No Hos	pital: 1   Inpatient 2   ER/O		4   Nursing Home 34	Residence (		)
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours alide death.  To the Funeral Director: After this certificate hacompletely filled in by the funeral director, page	Certification;	2 Accident investigation			'es 2 □No 281. Locati	on (Street and Town, State	d Number or Rural	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical C	29a. Certifier 12 Certifying Physic (Check only one)	an: To the best of my knowledg : On the basis of examination ar and manner stated.	e, death occurred at the tim nd/or investigation, in my op	e, date and place, and due to inion, death occurred at the t	the cause(s) me, date and	and manner as sta place, and due to	ated. the cause(s)
	To the within To the To the comp	Me	29b. Signature and title of certifier	han-		35779	Au		2006
	+		30. Name and address of person who comp W, Bouce Ober 31. Date filed (Month, Day, Year)	s hain, 25/32. Registrar's Signature	(Type, Print) S, Bohemi	a Ave., leco	Iton	, md. 2	1913-0678
	Sta Registr		SEP - 1 200	No.	( Agas)			lug <sup>®</sup>	

Damanuel Antjuan Barnes

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 29686

		1- For State Registrar			$C\epsilon$	ertificate	of De	eath			Re	eg. No.		
Physicia	n/	1. Decedent's Name (First, Midd	le,Last)								Date of Deat	h		3. Time of Death
ledical Examin	er	DaManuel Antju	ian Ba	rnes						l A	<sup>Month</sup> .ugust 26	, 2006 Ye	ar	0431 hrs
		4a. Facility Name (if not institution 6400 Wilborn Drive	n, give stree	et and num	iber)			ity, Town, or L apital Heigl		eath		4c. County Prince (		
Funeral		5. Social Security Number	6. Sex	7	. Age (In yrs.	last birthday	y) If	Under 1 Year	If Under 24	4Hrs.   8.	Date of Birt			thplace (State or
Director		213-19-9498	1 <u>X</u> M	2 F	18		Yrs M	onths Days	Hours	Min	1/30/		Foreig	
any	}	Usual Residence of Decedent  10a. State 10b. County			10c City	, Town or L	ncation							10d Inside City Limits
ž .	Ì	Maryland Prince	Geor	O P		pito1		htc						1 X Yes 2 No
Maryland 28a-f show d at once.	핡	10e. Street and Number		<i></i>	- Our	7101					13.			
or 28a	Director	609 Cappy Avenu	ıe				101.	Zip Code 20743			10	og. Citizen of W USA	hat Cour	ntry?
vith the s 23a s 23a	٦	11. Marital Status		Was Dece	dent Ever in U	IS 13	Was Dec	cedent of Hisp	anic Origin?	/ Specifi	/ Yes or No		Amori	can Indian, Black,
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Titem 27 is marked other than "natural", or items 23a or 28a-f shu rraumatic event, the Medical Examiner must be notified at once	Funeral	77		Armed For Yes		,	If Yes, sp	pecify Cuban,	Mexican, Pu	erto Rica	an, etc.)		e, etc.	
after al", o	à.		orced If Yes	tes:		1	Yes	2 X No	specify:			Specify	В	lack
hours a "natura"		15. Decedent's Education (Spe	_		_			sual Occupation working life. I			done	16b. Kind of Bu	usiness/I	ndustry
5036 within 72 iene. er than "	Completed	Elementary/Secondary (0-12)	1	ollege (1-	1 or 5+)		• •	0 1	ı			** 6 6		
5-0036 led within 72 tyglene. other than the Medical	탉	17. Father's Name (First, Middle,		+1		Sect	urity	7 Guard		lame (Fir	st Middle M	U.S. Se	cur	ity Service
215-0036 be filed within 7 ntal Hyglene. rked other than ent, the Medica	Be C	DaManuel Qu									arnes	raideri Garrianie	• )	
213		19a. Informant's Name/Relations	hip (Type, F	rint )	= .	19b. Ma	ailing Add	ress (Street	and Number	or Rura	Route Num	ber, City or Tow	n, State,	Zip Code)
MD id 2 sho Ith and n 27 is	1	Tawana Owens/M	other			609	Capp	y Aven	ue, Ca	apit	ol He	ights, l	D 20	0743
re, land Heal Heal	Ī	20a. Method of Disposition  1 X Burial 2 Cremation	2 D				sposition i	(Name of cem-		Da		20c. Location		
Pages hent of ant: If		4 Donation 5 Other St		emoval from	Ma Ma	-		ional	Cem 9	9/2/	2006	Laurel,	MD	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	1	21. Signature of Funeral Service		-00		1	22. Name Fort	and Address of Lincol	of Facility n Fund	eral	Home	twood, 1		
	-	23a. Part I. Enter the disease, or	complication	ne that car	read the deat	- I	3401	Blader	sburg	Rd.	Bren	twood, I	1D :	20722
Physician /Medical		failure. List only one cause	on each line	∍.			ter the me	oue or uying, a	ucii as caiui	ac or res	piratory arre	sst, snock, or ne	art	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)			onsequence								_	Deau
		Sequentially list conditions,	b											
	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause		oras a c	onsequence	of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a c	onsequence	of):							_	
ecutec and trans			d											
760, cate be ex physician he burial	n/Medical	UNPENDED	AMI	ENDED										
18760, tificate bo	Š,	IF FEMALE: 23b. Was decedent pregnant in th		Live bir	utcome of pre				75-1			23d. Date of		
30x 687 death certific e attending ;	ä	past 12 months?	4	_	เก nt at time of d		Fetal de		Ectopic pre	egnancy		Month	D	yay Year
Box te death c the atten the atten red for us	Physicia	1 Yes 2 No 9 Uni	known 9	Unknov	/n		outer (	open,)						
ords, P.O.	by P	Part II. Other significant condit	ions contr	ibuting to	death but not	resulting in t	he underl	ying cause giv	ven in Part I.					the cause of death?
S, P	힣					<del> </del>				- !	1 Yes	2 <b>V</b> No 3	Prob	ably 4 Unknown
cord	plet									_ [	24a Was a autops			topsy findings available ompletion of cause of
of Vital Records,  ng Physician: The law require the this certificate has been si meral director, page 2 should be	Completed										perform		death?	s 2 No
tal Rectian: The certificate ector, page	OΙ	25. Was case referred to medica							of Death (Che	eck only	one)			
Vit.	0	examiner? 1 ✓ Yes 2 No	Hospita	al: 1 In	patient 2	ER/Outpat	tient 3	DOA	other Nu	ursing Ho	me 5 I	Residence 6	<b>/</b> Other	Scene
n of ing P	اڃَ	27. Manner of Death  1 Natural 5 Pene	1 ,	Ba. Date o	f Injury Day,Year)	28b. Time FOUND		28c. Injury		ISu#	Describe h	ow injury occurr	ed	
Sior tttend death. ctor:	뜷	J Pelic	stigation	Aug 26, 2	006	0420 hrs	3		es 2 🗸 No	- Our	,,001 31101		-	
Division tal or Attendi rs after death. al Director: A led in by the fi	Certification:	dete	d flot be			nome, farm,	street, fac	tory, office bu	ilding, etc.	- 1	or Town. St	ate)		ral Route Number, City
Ospital ospital hours a uneral I		4 Momicide	- 4.		Bus stop					-		n Drive, Cap		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only one) 1 Certifying Pl	miner:On th	ne basis of	examination	dge, death o and/or inves	ccurred a tigation, ir	t the time, date n my opinion, a	e and place, death occurr	and due ed at the	to the cause time, date a	e(s) and manner and place, and c	as starte lue to the	ed. e cause(s)
To To con	ĕŀ	29b. Signature and title of certifie	and r	nanner sta	ted	7		29c. License				29d. Date sign		
		(1200	P	HE	el C	Ja 1		O.C.M	I.E.			August 26,		
	ŀ	30. Name and address of person	who comple	eted cause	of death (Iter	n 23a)								
CK(3)			sistant M				nn Stree	et, Bałtimo	re, MD 21	201				
Sta		31 Date filed (Month, Day, Year) SEP 0 6 2	000	Reg	istrar's Signal	Uro.	-	,						<del></del>
Registr	200	SEP 0 6 2	HHK	Plane.		Neg	40.0							

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certi	ficate of	Death			Reg. N	lo. <b>2</b>	UU	6 296	C
Physici		1. Decedent's Name (First, Mide	lle,Last)					2. Date of		V		3. Time of Death	_
Medical Exami	ner	KAREN	D.	BARNES				Month Septer	Day nber 4,	<sup>y</sup> 2006 <sup>Yea</sup>	ir	1546 hrs	
The state of the s		4a. Facility Name (if not instituti	on, give street and n	number)	4	b. City, Town, or	Location of D	eath	T	4c. County of	of Death		_
		Prince George's Hos	oital Center			Cheverly				Prince G	eorge	's	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	r If Under 2	4Hrs. 8. Date	of Birth (M	M/DD/YYYY		hplace (State or	_
Director		579-84-8488	1M 2.XXF	49	Yrs,	Months Days	Hours	Min. 7////	F 30	1957	Foreig Cou	n untry) $\mathcal{DC}$	
		Usual Residence of Decedent		-1/_	110,	<u> </u>		Jun	,	1751			_
any		10a. State 10b. County	•	10c. City, To	own or Location	on						10d. Inside City Limits	,
<b>*</b> .	.	MD PRINC	E GEORGE	Д1/	ATTOUT	115					i	1 XXYes 2 No	,
Aaryland 28a-f show Lat once.	흱	10e. Street and Number	LOLUNOL	119	ATTSV1	10f. Zip Code			140- 0	itizen of Wh			_
Mar r 28; ed a	Director		TT00:05									ury?	
215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene.  rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		855 LACEWOOD				207				. S. A			
h wi cms	Funeral	11. Marital Status 1 Never Married 2 X		ecedent Ever in U.S. Forces?		Decedent of His es, specify Cuban				14. Race White		can Indian, Black,	
deat or it	5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 Yes	2 XX No				ante Modifi, oto.	,	7411110	, 010.		
after iner	by		vorced If Yes, Give Ye or Dates:		1	Yes 2X No	specify:			Specify:	BI	LACK	
5-0036 led within 72 hours Hygiene other than "natur the Medical Exam	柡	15. Decedent's Education (Sp				's Usual Occupati ost of working life.			16b	. Kind of Bu	siness/Ir	ndustry	
6 72 } cal E	Completed	Elementary/Secondary (0-12	College	(1-4 or 5+)	damigine	ost of working life.	DO NOT use	o retired)					
on thir the steel	ᇤ	12TH GRADE			MEDICA	L TECHNI	ICIAN		P.	G. H	OSPI	ITAL	
5-0 led v Hygir othr		17. Father's Name (First, Middle	e, Last)			1	18.Mother's N	lame (First, Mid	dle, Maide	en Surname)			_
21215-003 ould be filed within I Mental Hygiene i marked other the icevent, the Medi	a	JOHN H, BENNE					CEC 11	L JOYCE	BAIN	IES			
D 21 should I and Mer 7 is man	ို	19a. Informant's Name/Relation			19b. Mailing	Address (Street	t and Number	r or Rural Route	Number,	City or Town	n, State,	Zip Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Pygiene tant: If item 27 is marked other than or other traumatic event, the Medica		CECIL JOYCE B	ENNETTM	OTHER	3530 A	MES ST., tion (Name of cen	N. E.	. WASH.	., DO	2001	9		
		20a Method of Disposition	. [	20b. Pla	ce of Disposite	tion (Name of cen	netery,	Date	200	c. Location -	City or	Town, State	_
Baltimore, permit Pages I an Department of He Important: If ite		1 XBurial 2 Crematic				CEMETER	2V   0	9-8-06	SI	ΙΤΤΙ ΔΝ	D A	(D	
Itin it P irtme ortan	- 1	4 Donation 5 Other 5 21. Signature of Funeral Service										ERAL TICAL	
Baltimo permit Page Department of Important: injury or oth		11. 1	~ +	6.		4 – 8TH							
Physician		23a. Part I. Enter the disease, of	complications that	kney caused the death D								Approximate Interval	_
/Medical		failure. List only one cause	on each line.	0	375		odor do odra	ide of respirator	y arrest, s	TIOCK, OF THE	a) (	Between Onset and	
≒xaminer		Immediate Cause (Final diseas or condition resulting in death)		ive Cardiovasci	ular Disea	se						Death	_
		or condition resulting in death)	Due to (or as	a consequence of):									
	5	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):					_		_		-
	Examiner	cause Enter Underlying Cause		a 55/155qa5/155 5/7.									
	ä	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):									
cuted	빏		d							_			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and inplietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	AMENDED										
8760, tificate bong physicas the burner	ğ	IF FEMALE:		outcome of pregnar	псу	-			12	3d. Date of	delivery		_
687 certific	au/	23b. Was decedent pregnant in t past 12 months?	I I LIVE	birth	2 Fet	al death 3	Ectopic pre	egnancy		Month	D	ay Year	
Box (e death ce the attence of for use	Si	1 Yes 2 ✔ No 9 Ur	known	ilani ai ilile oi deati		er (Specify)							
P.O. Box 687 s that the death certific gned by the attending F detached for use as the detached for us	Physicia		9 Unki										
P.O. es that the igned by	Ϋ́	Part II. Other significant cond		to death but not resu	ilting in the ur	nderlying cause gi	iven in Part I.				_	he cause of death?	
ires i	Completed by	Seizure Disorder; M	orbid Obesity					_ 1	Yes 2	No 3	Proba	ably 4 🗹 Unknown	
ords,	ete								Vas an utopsy			opsy findings available impletion of cause of	,
e law e law e las e 2 :	티				•			— I _ p	erformed'	? d	eath?		
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been side in by the funeral director, page 2 should be	a	examiner?	Hospital:	Innetional OFFICE	R/Outpatient		Othor:				7		_
f Vi	٢	1 ✓ Yes 2 No 27, Manner of Death	280 Date		8/Outpatient 3b. Time of In			ursing Home 5		dence 6	Other:		_
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SiOr attend death ctor: y the	ā		ding stigation	-3.55			es 2 No	<u>'</u>					
Divisi spital or Ati ours after d erat Direct filled in by	۱ij		id not be	ce of Injury - At home	e, farm, street	t, factory, office bu	uilding, etc.		on (Street /n, State)	and Numbe	r or Rur	al Route Number, City	
Spita tours	Certification:	4 Homicide	ermined (Specify	)				71.7	,,				
e Hos 24 h e Fur etely	- 1			est of my knowledge,									1
Division  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Medical	one) 2 Medical Ex	aminer: On the basis and manner	of examination and/ stated	or investigation	on, in my opinion,	death occurr	red at the time, o	date and p	place, and du	ue to the	cause(s)	
	ž	296. Signature and title of certif	9			29c License	number		290	. Date signe	d (Mon	th, Day, Year)	
	1	I aml	uleel			O.C.N	И.E.		Se	eptember	5, 200	06	
0	(	30. Name and address of perso	who completed cal	use of death (Item 23	sa)								_
CK		·	ssistant Medic		,	Street, Baltim	nore, MD 2	21201					
9	ate	31. Date filed (Month, Day, Year,	<b>2</b> €. R	tegistrar's Signature	- /								4
	trar		2006	K	Cornel	1							ļ

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of I</i>			ieneZ () •g. No.	U b	29688
ı	Physici	an	1. Decedent's Name (First, Middle					2. Date of Deat Month	h	Year	3. Time of Death
	Physici /Medic		JESSIE		THEA			AUGUST			5:36A M
	Examin	er	4a. Facility Name (If not institution			,	Location of Death		4c. County		
7	Funcual		FORT WASHINGTO  5. Social Security Number		ENTER e (In yrs. last birthday)	<del>                                     </del>	WASHINGTO	N 8. Date of Birth			GEORGES
	Funeral Director		247 26 5497	XXM 2□F	84 Yrs.	Months Days	Hours Min.	(Month, Day, SEP. 20	Year)	SOUT!	elace (State or Foreign etry) H CAROLINA
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				1	0d. Inside City Limits
	Manyli f sho	Į.	DC		WASHING					1	XXYes 2 □ No
	r 28e-	Director	10e. Street and Number		WASIIING	10f. Zip Code		1	0g. Citizen of	What Coun	ntry?
	th with	ai D	716A PARKSIDE	PLACE, NORTH	EAST	2001	9		UNITE	ED STA	ATES
	ams ams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spo	ecify Yes or No-		ce - Americ	
	ba filed within 72 hours after death with the Maryland nat Hyglene. ad other than "natural", or itams 23a or 28e-f show ovent, the Macabal Exerciting recounties and illed at	ρχ	1 Never Married 2 Married 2 Married 4 Divorced		No	1 ☐ Yes ŽXNo	Specify:	, noarr, oto.,	Specif		
ל ל	72 ho	etec	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of B	usiness/inc	dustry
٧	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	p+)		)		MT337.		
3	filed Hygir Sther ent, II	e Co	UNKNOWN 17. Father's Name (First, Middle,	Last)		NISTER	18. Mother's Name	(First, Middle, N	MINIS Maiden Suman		
ğ	2 should ba filed withir and Mental Hygiene. Is marked other than aumatic event, Ihe M	o B	THOMAS BETHEA				PAULINE	UNKNO	OWN)		
	m 49 -		19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street a				State, Zip	Code)
1	and 2 salth a n 27 ls		ELIZABETH PARK	ER / DAUGHTE		T. ANDREW		FT. WAS	SHINGTO	ON, MI	20744
ם ס	of He		20a. Method of Disposition AB Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other plac	θ)	Date	20c. Location	City or To	wn, State
	t. Pag tment tant: ijury o		`4 □Donation 5 □ Other (S	oecify)		CEMETER!				TON,	
2	permit. Pages 1 and 2 Department of Health s Important: If Item 27 li any injury or other tra once.		21. Signature of Funeral Service	Lizensee		MARSHALL					
			23a. Part1. Inter the disease, or	complications that caused	the death. Do not en	4308 SULT ter the mode of dying			AND, ML	2074	Approximate
	Physician <sup>1</sup>		Immediate Cause (Final	only one cause on each li	ne.	. 40	-				Interval Between Onset and Death
ľ	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	arter	y dise	420			
	Examiner		Sequentially list conditions	1 Dia	beter		•				
1	ם א	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	and and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (b) as	a consequence of):	10n					
, S	w requires that the death certificate be exacuted been signad by the attending physician and should be detached for use as the burial-transit	aiE		Due to plas	a consequence or).						
	ficate p physis the	edicai		d							
	eath certi attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		75-1			23d. Da	te of delive	ry
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at		□Ectopic pregnancy □ Other <i>(specify)</i>			Mo	onth	Day Year
	at the	Phys	9 Unknown								
ָרָ מַ	ires th signad	by	Part II. Dther significant condition	ns contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.		acco use cont		ably 4 Unknown
5	requiper /	etec									/ /
	has l	Completed	-					24a. Was at autops perforn	/	Were autor prior to con death?	psy findings available npletion of cause of
3	icien: The lav certificate has ractor, page 2	e Co	25. Was case referred to medica				00 81 ( 8	1 Yes 2	No	1 🗌 Yes	2□ No
	/sicie s cert diracto	0 B	examiner?	Hospital:	nt 2 ER/Outpatier	nt 3 DOA Othe	26. Place of Death	ne 5 ☐ Reside		er (Specific	<u> </u>
5	g Phy er this	-	27. Manner of Death	28a. Date of Inju	y 28b. Time o		at	28d. Describe ho			/
2	andin sath. or: Aft	atio	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	jation	, roas, injury		Yes 2□No				
	To the Hospital or Attending Physicien: The law requires that the death cerwithin 24 hours after death within 25 hours after death. To the Lungel Directors After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Numb , State)	er or Rural	Route Number,
•	spital		29a. Certifier 1 Certifyir	g Physicien: To the best	of my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the ca	use(s) and ma	anner as sta	ated
	he Ho in 24 h ha Fu pletely	edicai	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my op	pinion, death occurr	ed at the time, da	ite and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifie			29c. License			d. Date signe	d (Month, L	Day, Year)
	(1)		· n	TW		100	0531	17	8/30	10	6
garin-	4)		30. Name and address of person PATRICK DALY,		eath (Item 23a) (Type. 1711 LIVIN		FORT W	ASHINGTO	ON, MD	20744	ŀ
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 0 7 20	22 Pagiste	ar's Signature				-		
			251			11-					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental	Hygiene 2	21	0	0	6
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29689 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Aug. 27, Day 2006 8:30 a M **Physician** Year Thomas W. Beyer, Sr. /Medical 4a. Facility Name (If not institution girls tree and surface Apts. 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester 1360 Cambridge Beltway 8. Date of Birth (Month, Day, Year) Jan. 22, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Yrs. Director 139-48-0531 5.3 1953 New Jersey Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Madical Examinat must be notified at 1 Nes 2 No Dorchester Maryland Cambridge 10e Street and Number Woods Crossing Apts. 10f. Zip Code 10g. Citizen of What Country? Saltimore, Maryland 21215-0036 1360 Cambridge Beltway 21613 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Painter Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Itam 27 is marked othe any Injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be To Louis C. Bever <u>Myra Wicklisse</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Beyer, Jr./Son 440 Park Ave., Mt. Pocono, PA 18344 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ €remation 3 ☐ Removal from State MidShoreCremationCenter 8/29/2006 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Mid Shore Cremation Center, P.O. Box 1464, 2272 Hudson Rd., Cambridge, MD 21613 21 gnature of Fun val 5 rvice Licensee Turilan 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anterioscle **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death P.O. F 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. ours after death.
neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALHTER men's Lane MAHBUBA 607 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment o	f Healtl of Dea	h and M th	F	leg. No.	
ı	Physici /Medic		Decedent's Name (First, Middle, Las     Clyde Alexander		, Sr.				2. Date of Dea Month August	Day Yea 31, 2006	
	Examir		4a. Facility Name (If not institution, give		tal	4b. City, Tow	n, or Location			4c. County of De	eath
	Funeral Director				In yrs. last birthday,		ar If Und		8. Date of Birth (Month, Day 1/8/42		Birthplace (State or Foreign Country)  aryland
	Maryland a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Md • P	•G•	Oc. City, Town or L						10d. Inside City Limits
	with the	i Direc	10e. Street and Number 2116 Catskill S	treet	•	10f. Zip Cod	ө	20748		10g. Citizen of What	
36	be filed within 72 hours after death with the Maryland stal Hygliene.  do other then "naturel", or ltems 23a or 28s-f ehow event. Its Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent II Yes, specify ( 1 ☐ Yes 2 ☒		Origin? (Spe ican, Puerto F		14. Race - Ar Black, Wi	nerican Indian,
1215-0036	within 72 hou ene. then "nature te Medicel E	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0·12)	ucation	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during n tired)			16b. Kind of Busines	,
z pu	d a b	Be	12th 17. Father's Name (First, Middle, Last)		Cla	rtered I	18. Mc	ther's Name	(First, Middle,	Maiden Sumame)	rtation
Maryland	should nd Mer marke	욘	Walter Bernett  19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Str			Hollane	r, City or Town, State	, Zip Code)
	1 and 2 Health a tem 27 le		Maxine M. Bernett					_		Maryland	
altimore,	Pages '		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Dispo cemetery, createry Harmony	matory or other	olace)	9/6/0	ate 06	Landover,	
Balti	permit. Pages Depertment of Important: If It any Injury or o		21. Signature of Funeral Service Licens	W Pia	2:	2. Name and Ad H . S . Wa	dress of Fa	cility Ton &	Sons Co	o.,Inc.	
	Icate be executed  /Medical Examiner s the burial-transit	edicai Examiner	23a. Part1. Enter the disease, or composition, or heart lailure. List only of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	Neumann	tying, such	as cardiac or	respiratory arr	est,	D.C.20019 Approximate Interval Between Onset and Death
C BOX	certil ding Ise a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 [ 4□Pregnant at tim 9□ Unknown	Fetal death 3	Ectopic pregna Other (specify				23d. Date of d Month	elivery Day Year
ecords, P			Part II. Other significant conditions co	,	not resulting in the u	nderlying cause	given in Pa	rt I.			to the cause of death?  Probably 4 □Unknown
r	The law ete has b page 2 s	e Completed	25. Was case referred to medical						24a. Was a autops perform	prior to death? 2 No 1 Ye	autopsy lindings available o completion of cause of
2 2	Physiclan: r this certific ral director,	ToB	examiner? 1 Yes 2 No	lospital: Inpatient	2 ER/Outpatier	IL SEL DOA	Other: 4 🗆		(Check only on e 5 ☐ Reside	e) ence 6 □Other (Sp	өөсіғу)
<u>_</u>	or Affer Ing	ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time o		ijury at Vork? Yes 2	,	Bd. Describe ho	ow injury occurred	
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	Specify)				City or Town		
	te Hosp te Fune detely fil	edicai	29a. Certifier (Check only one) Certifying Phy	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	n occurred at the vestigation, in m	time, date y opinion, d	and place, ar leath occurre	nd due to the ca d at the time, d	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
	To the within 2 To the Complet	W	29b. Signature and hite of certifier	My			2055		2	9d. Date signed (Mor	nth, Day, Year)
_	(3)		30. Name and address of person who c	, ~	. /	Print)		SE Ju	atr 3	O Wash	ingha DC 20032
	Sta Registra		31. Date liled (Month, Day, Year) SEP 0 5 2006	32. Registrar's		•	- 90/ 1	- V4	110		7/01/100 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar 29691 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year August 31, 2006 Joseph Travis Buck 12:49 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Ft. Washington Prince George's | Hunder 1 Year | Hunder 24 Hrs. | B. Date of Birth (Month, Day, Year) | Nov. 14, 1936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1√2M 2□ F 69 Yrs. 205-26-2374 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits

10f. Zip Code

20744

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 24 X No

Approximate Interval Between Onset and Death

10g, Citizen of What Country?

Specify:

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

14. Race - American Indian, Black, White, etc.

White

USA

10c. City, Town or Location

Ft. Washington

**Funeral** Director

10a State

Mary land

11. Marital Status

10e. Street and Number

Directo

Funeral

10b. County

7500 cardinal Lane

1 Never Married 2X Married

Prince George's

12. Was Decedent Ever in U.S. Armed Forces?

with the Maryland item 27 is marked other than "natural", or items 23e or 28a-1 show other traumatic event, the Nedical Examinat must be notified at 72 hours after permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "reny liury or other traumatic event, II = Next Optica.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examiner use as the burial-transit The law requires that the death certificate be executed the attending physician P.O. Box 68760 Physician/Medical Š Division of Vital Records, by Completed Be Certification:

To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Medical

1 XXYes 2 □ No 1955— If Yes, Give Year or Dates: 1958 1 ☐ Yes 2 ◯XNo Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunication Equip. Operator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Homer V. Buck Helen Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily E. Buck / Wife 7500 Cardinal Lane Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cemetery 09/05/2006 Cheltenham, Maryland \* 4 ☐ Donatiop 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur A Funeral Service Licensee George P. Kalas Funeral Home PA clas! 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Fart I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final E sophaged
Due to (or as a consequence of): CANCOL disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

11701 Livingian Road Fort WASHington, may land William T. TAMER Mn. 31. Date filed (Month, Day, Year) SEP 0 5 2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

73650P

Registrar

			For State Registrar	State of Maryland	Department of He Certificate of D	ealth and Me D <i>eath</i>	ntal Hygien Reg. N	$ \sim$ $\sim$ $\sim$ $\sim$ $\sim$	29692
	Physici	an	1. Decedent's Name (First, Middle, Last				Date of Death Month Da	ay Year	3. Time of Death
9	/Media	al	Aa. Facility Name (If not institution, give	Street and number)	4b. City, Town, or I	ocation of Death		5 <i>მბბ (</i> c. County of Death	
	Examir Funeral Director	),CE	University of Mary  5. Social Security Number 6. Se	and Med Cent	er Baltimor	If Under 24 Hrs. / 8		Baltimere  9. Birth Con	City hplace (State or Foreign unity) Shingten, DC
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
	Maryl I-f sho	tor	AV	Ale	exandria				1 Yes 2 No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 432 A Cook S		101. Zip Code 22314	4		itizen of What Co	untry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumetic event, the Medical Examinat must be notified at	ģ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Norced	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No	panic Origin? (Speci , Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Bl	e, etc.
Maryland 21215-0036	d within 72 ho plene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 1 e completed) College (1-4or 5+)	6a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	uring most of working	Af	Kind of Business/I Artme Wlaing	nt
/land	2 should be fited and Mental Hygi is marked other aumetic event, it	To Be C	17. Father's Name (First, Middle, Last)	~		18. Mother's Name (	First, Middle, Maide	n Sumame)	
Man	d 2 shoul th and Mary 7 is mark traumet	1	19a. Informant's Name/Relationship (T) Abbie Moore I Mo	pe. Print)	19b. Mailing Address (Street ar	nd Number or Rural I			
	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition	20b. Place	e of Disposition (Name of etery, crematory or other place	Dat		Location - City or	
ij	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	opolitan Crema	tery 9/1		exandrix	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other 90ce.		21. Signature of Funeral Service Licens  Nelson & Helen	ee A	22. Name and Address SI4 Frank	s of Facility 6-78	ene Fun Hexandr	ieral He	2314
· v	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the death. It is cause on each line.  Pontine	oo not enter the mode of dying	, such as cardiac or I	espiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):	LSe			two years
68760,	ficate be executed physicien and is the burial-transit	ai Examîner	Securitally intenditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c sequence Due t (or as a consequence					three weeks
P.O. Box 68	death certi	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic pregnancy			23d. Date of deli	ivery Day Year
	The law requires that the ate has been signed by the bage 2 should be detache	Ď	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the underlying cause giver	n in Part I.		1	the cause of death?
Division of Vital Records,		Completed	Hypertension Periodeval V	asculat disea	ase		24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of 2 No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	formitals &	Other	26. Place of Death (			
of	g Phys er this eral di	n: To	27. Magner of Death	1 Mainpatient 2 EH	b. Time of 28c. Injury	at 28	5 Residence d. Describe how inj		cify)
vision	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director.	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home		es 2 🗆 No	f. Location (Street a City or Town, Sta		ural Route Number,
۵	Hospital or 24 hours atte Funeral Dir stely filled in I	ai Cert	29a. Certifier 1 <b>☑</b> Certifying Phy	building, etc. (Specify) sician: To the best of my knowle	dge, death occurred at the time	e, date and place, an	d due to the cause(	s) and manner as	stated.
	the Ho in 24 h the Fu ipletely	ledical	(Check only 2 Medical Exemi	ner: On the basis of examination and manner stated.	and/or investigation, in my opi	inion, death occurred	at the time, date ar	nd place, and due	to the cause(s)
	To the within 2.  To the complete	M	29b. Signature and title of certifier  Richard A. C	Unight MI	29c. License		1	ate signed (Month	A = /
7	(4)		30. Name and address of posin who co	1 40 3 1 4	n ( MA )	7 W 2 C 1	21 c	J. C	1 12 all 1 a co
	Sta		31. Date filed (Month, Day, Year)  CFP 0 5 2006	32 Registrar's Signature		TO MICE OF	4 MA SOLL	M (LASEN )	4, Baltinose MD, 21201

			1 - State Registrar	State of Marylar		artment of F		lental Hygi	ene g. No. 200	5 29693
			1. Decedent's Name (First, Middle, Las	t)		<del></del>		2. Date of Death		3. Time of Death
	Physici /Medio		KENHETH BR	ANDONBURG,	I			Septemb	er 4 200	6 0235 AM
) .	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, a	Location of Death		4c. County of Dea	ath
			WASHINGTON COUNTY				ERSTOWN			SHINGTON
н	Funeral Director		5. Social Security Number 6. Social Security Number 1	VIM 2□F	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign country)
н			Usual Residence of Decedent	62				JUNE 16,	1944	MARYLAND
	how		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Ba-f-	Director	MARYLAND WASHING	STON		KEE	DYSVILLE			1 Yes 2 No
	or 2	洁	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	country?
	• 23e	Funerai	54 SOUTH MAIN STE		15 10 1	Mar Daniel at 1	21756	ad Van as No	14. Race - Am	S.A.
	er de	Ş	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in L Armed Forces?	65_ 13.	If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)	Black, Wh	
215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 ehow Jigal Exactinat the motified at	þ	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No 19 If Yes, Give Year or Dates: 19	67	1□Yes 2⊠ No	Specify:		Specify:	WHITE
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occup	ation during most of worki	00	6b. Kind of Busines:	
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	9		
21	fygier tygier her ti	ပိ	12 17. Father's Name (First, Middle, Last)			CABLE_SP	LICER 18. Mother's Name	/First Middle N		IE COMPANY
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental thysiene. Importent: If item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow applyingry or other treumatic event, the Medical Examination in the political at an access.	Be	KENNETH LEE BRANG	TENRUDG				LOUISE (	•	
7	should nd Me mark matik	2	19a. Informant's Name/Relationship (1		19b. Mailir	ng Address (Street)			City or Town, State,	Zip Code)
<b>∑</b>	and 2 state and 2 state and 27 is		LUCINDA BRANDENBU	IDG/WIFF		. MAIN ST			MARYLAND	21756
Ē,	S 1 and Head Item		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of matory or other place		A SECTION OF PERSONS	Oc. Location - City o	The state of the s
Ē	Page nent c nnt: If iry or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		CEMETERY	1	2/2006 8	EEUACATITI	E. MARYLAND
Baltimore,	permit. Departnimports Imports eny inju		21. Signature of Funeral Service Licen		22	. Name and Addre	ss of Facility		National	
8	\$2E 5 8		K	elly A. Zimmer	rman BA	ST FUNER	AL HOME	<u>Boonsbor</u>	o, Maryla	nd 21713
			23a. Part1. Exter the disease, or minimum shock, or heart failure. List only	dications that caused the deal one cause on each line.	th. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	. HYPERTEN	SION					YEARS
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	ruence of):	· · · · · · · · · · · · · · · · · · ·				
	uted J ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events		,					
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9	± 0 €		IF FEMALE:							
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	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5∟	Other (specify)				-
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Records,	quires n sign	d by	HYPERLIPIDE	MA				1 ☑ Ye	s 2 No 3 P	robably 4 Unknown
000	sw requir s been si 2 should	Completed						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Re	o - 0	lwo:						autopsy perform	ed?   death?	s 2 No
ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical exeminer?				26. Place of Death			
of Vital	Physician: this certificatal director, i	ို	1 ☐ Yes 2 ☑ No		ER/Outpatier		4 Chansing no	-	nce 6 Other (Spe	ecify)
n	Attending P r death. octor: After ti by the funera	inol	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe hor	w injury occurred	
Division	Attending or death. ector: Atterby the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ome farm etr		Yes 2 □ No	28f Location /Str	eet and Number or F	Rural Route Number
Ď	after Direct	Certification:	4 Homicide determined	building, etc. (Speci		eet, lactory, office		City or Town,		rural Houle Number.
	Hospitel A hours Funerel tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, deatl	occurred at the tin	ne, date and place,	and due to the ca	use(s) and manner a	is stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai	(Check only 2 Medical Examone)	iner: On the basis of examina and magner stated.	ation and/or in	vestigation, in my o	pinion, death occurr	ed at the time, da	te and place, and du	e to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	2 /		29c. Licens		29	d. Date signed (Mon	th, Day, Year)
			ノルカ	Shows		D59	2019		SEPTEMBER	5,2006
74	H-38+1		30. Name and address of person who				C_ S	- 200	1100000	
	Sta	100	STEVEN BLASH 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	THE THIM	ST SUIT	203	HAGEROCK	0m, mD
	Registi		SEP 0 7 20			ule				4190

			1 - For State (		artment of Health and ertificate of Death	Mental Hygier	7000 /9694
1	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Mitzi Laverne	Boyer		2, Date of Death Month	Day Year 7'.42 A M
	Examin	er	4a. Facility Name (If not institution, give street and not all the street all the street and not all the street all the street and not all the street and the street all the s	ndens	4b. City, Town, or Location of De Chester to u	on	4c. County of Death  Kent
2	Funeral Director		5. Social Security Number  2.18-92-6499  Usual Residence of Decedent	7. Age (In yrs. last birthday, 45 Yrs.	Months Days Hours Mi		9. Birthplace (State or Foreign Country)  961 Maryland
	death with the Maryland ime 23a or 28e-f ahow if inval by ricilified at	tor	10a. State 10b. County  Maryland Kent	10c. City, Town or L Chest	ocation fertown		10d. Inside City Limits 1 Yes 2 □ No
	th with the 23a or 28a	al Direc	10e. Street and Number 335 Calvert Ga	rdens	10f. Zip Code 21620	10g.	Citizen of What Country?
036	hours after dea turai', or iteme	by Funeral Director	11. Marital Status 12. Was De Armed F	cedent Ever in U.S. 13. forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 ☐ Yes 2 ☐ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:  Black
21215-0036	within 72 ene. than "na	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College	(Give (1-4or 5+)	edent's Usual Occupation e kind of work done during most of w DO NOT use retired)  Fchen Helpe	rorking	Estaurant
		To Be Co	17. Father's Name (First, Middle, Last) Thomas L. Boyer			ame (First, Middle, Maid	den Sumame)
, Maryland	nd 2 s ulth ar 27 ia r treu		19a. Informant's Name/Relationshi (Type, Print)  La Keshia L. Boyer/				ry or Town, State, Zip Code)  Town, Md. 216 20  Location - Cily or Town, Slate
Baltimore	0 0		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State CAPIT	AL C. Renden 9	12/06 -	Dover, DE.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Juneral Service Licensee		22. Name and Address of Facility Bennie Smith F 17 N. Division St.	uneral Ho Dover, De	me . 19904
	Physician		23a. Fart . Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	caused the death. Do not en each line.	nter the mode of dying, such as card	ac or respiratory arrest,	Approximate Interval Between Driset and Death
10 mg/m	/Medical Examiner		resulting in death)  Sequentially list conditions,  b.	or as a consequence of):	0	7 1	
	ate be executed shysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	o (or as a consequence of):  o (or as a consequence of):			
38760,	icate be er physicien s the buria	icai					
P.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Med	in the past 12 months?	gnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	sign d be	þ	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Vital Records,	The law ate has b page 2 s	Completed				24a. Was an autopsy performed	
	W 77	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatie	Other	Home 5 Hesidence	6 ☐ Other (Specify)
ion of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	e of Injury nth, Day Year) 28b. Time Injury	of 28c. injury at Work?  M 1 Yes 2 No	28d. Describe how in	njury occurred
Division	tai or Atten rs after deat ei Director: ed in by the	Certification:		ce of Injury - At home, farm, s ding, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or Al within 24 hours after of To the Funerel Directompletely filled in by	edical	(Check only 2 Medical Examiner: On the		ath occurred at the time, date and pla investigation, in my opinion, death oc		
)	To the To the complet	Σ	29b. Signature and title of certifier  Letter	5 Je	29c. License number 00603	301	Date signed (Month, Day, Year)
n	7 >			use of death (Item 23a) (Type	Peru RD ST	85 ct	65/20 Bus, MD
4.	Sta Regist		31. Date filed (Month, Day, Yell) 32. SEP - 6 2006	Registrat Signature	Les Comments		

State of Maryland / Department of Health and Mental Hygiene For State Registra 29695 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUGUST <sup>Year</sup> 2006 09:00 A™ HEINRICH BITTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHESTERTOWN NURSING & REHABILITATION CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth 11/02/1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-34-9531 86 RUSSIA Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 ie marked other than "natural", or iteme 23a or 28a-1 ehow ury or other traumatic event, the Medical Examinations and item of the province of the contractions o 1 Ves 2 No Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 MALONE AVE. 21620 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION MECHANIC 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARIA 'UNKNOWN' HEINRICH BITTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIA BITTER/WIFE 108 MALONE AVE., CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment o important: If any injury or 4 □ Donation 5 □ Other (Specify) CHESTER CEMETERY 09/02/2006 CHESTERTOWN, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM
130 SPEER ROAD, CHESTERTOWN, FUNERAL HOME, PA MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner dicen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Due to (or as a consequence of): physicien ar Division of Vital Records, P.O. Box 68760 Physician/Medical d for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant signed by the etter Id be detached for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 DNo 3 Probably 4 □Unknown 1 TYes Be Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate hes autopsy performed: 3 2 \( \text{No.} 1 ☐ Yes 2 10 No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 D Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Maturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death unerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funerel i

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ive, Chestertown, MD 415 ms Wash 31. Date filed (Month, Day, Year) Registrar Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryla	-			lealth a Death		ental Hyo	Reg. No.	2006	
)	Physici /Medic Examir	al	DOUGLAS      Aa. Facility Name (If not institution, give state)	WAYNE	BAUGH	4b. City	_	Location o	s	Month eptem!	ber 1	1,200 unty of Deat	h
	Funeral Director		218-38-7415		rs. last birthday) 65 Yrs.		eder er 1 Year Days	I C K  If Under 2  Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Oct. 17			hplace (State or Foreign untry) ginia
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28e-f ehow any injury or other treumatic event, the Madical Examinat must be inclified at ance.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Dm Road  12. Was Decedent Ever in Armed Forces?  1	16a. Dece (Give	Was Dec If Yes, sp 1 Yes	edent of Hi ecity Cuba 2 A No ual Occupa ork done cuse retired	Specify: ation during most		cify Yes or No- lican, etc.)	Un	ited S Race - Ame Black, White pecify: V	States ncan Indian, e, etc. White
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O. Box 68	he death certific / the attending p ched for use as I	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preduced the second of the second	etal death 3[	⊒Ectopic ⊒ Other (	pregnancy specify)				23d	. Date of del Month	ivery Day Year
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Ω	To the Hospitel or Attent within 24 hours efter death To the Funerel Director: completely filled in by the		(Check only 2 Medical Exami	building, etc. (Spe sician: To the best of my ner: On the basis of exam	cify)	th occurre	d at the tin	ne, date an	d place, a	City or Tow	vn, State) cause(s) an	d manner as	stated.
	To the P within 2- To the F complete	Medical	29b. Signature and title of certifier  June ME	and manner stated.		2	9c. Licens	e number	98		29d. Date s	igned (Mont	h, Day, Year)
ě	Sta Regist		30. Name and address of person who con the control of the control	ompleted cause of death (I WADHWA 32. Figistrar's Signature Signat	tem 23a) (Type)	, Print) 400 V	1. 7tl	h Str	eet,	Freder	ick, l	MD 217	01

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	Physici /Medio		Coordia Comple Browning		Ó 2006	3:05 P <sup>M</sup>
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e.	Director		234-78-8050 Usual Residence of Decedent  Ju	1. 31,	1948 MD	
	and and		10a. State 10b. County 10c. City, Town or Location		10	Od. Inside City Limits
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	3e or	Ö	429 Michigan Avenue 21740		USA	
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9	after or ite	F	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican,	etc.)	Black, White, e	etc.
8	ours a	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ Yes 2 ☑ ☑ Specify:		Specity: Wh	nite
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 show the Medical Exeminer must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. I	Kind of Business/Ind	ustry
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	1 and Healt		Wendy S. Browning daughter 429 Michigan Avenue Hage 20a. Method of Disposition (Name of Date		MD Z1/40 Location - City or Tov	
Ď	Pages nent of H int: If it		1 Rurial 2 Stremation 3 Removal from State cemetery, crematory or other place)			
Baltimore,	t. Partimer		4 □ Donation 5 □ Other (Specify) Cumberland Valley Crem. 09/16  21. Signature of Funeral Service Licensee 22. Name and Address of Facility M; 110.			
Bal	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.				sox Funer	
		-		treet G	reencastl	<u>e, PA 1/22.</u> Approximate
			23a. Part1. 3 ter the disease, or complications has caused the death. Do not enter the mode of dying, such as cardiac or respin shock, it heart failure. List only one cause on each line.		] .	Interval Between Onset and Death
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	To Con	2	29b. Signature and title of certifier	29d. Da	ate signed (Month, E	vay, rear)
			outere Horm V CSOCS	Ser	tenher	11 200P
	10		30. Name and address of person who completed cause of death (Nam 23a) (Type, Print)		1 1/	. )
			1 relieve It KASS III ms 11110 medical Camp	nus Ke	Hege	nwotz
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	Regist	GI	SEP 1 8 2006			

State of Maryland / Department of Health and Mental Hygiene 2006 29698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 205 Mary Elizabeth Foard Craig September 4, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 705 Alliance Street Havre de Grace | Havre de | State of Birth (Month, Day, Year) | Sept. 28,1921 Harford 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 🖾 F 213-16-4018 84 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or frame 23s or 28s-f show their rest by notified at 1 AYes 2 No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Alliance Street 21078 II.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify: Specify: r then "naturel", o þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry County Bank other then College (1-4or 5+) Two Years Elementary/Secondary (0-12) Havre de Grace, Maryland Vice President of Health and Mental Hygie filtem 27 ie marked other t r other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be innert of Health and Mental Int: If Itam 27 Is marked o ပ Thomas Randolph Foard Alberta G. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Emerson Craig (Husband) 705 Alliance Street, Havre de Grace, Maryland 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury Cemetery 09/07/06 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 S. WILL Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performe certificate 1 ☐ Yes 28 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify) 1 Yes 2 No ٤ 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 5 Pending investigation 1. Natural within 24 hours after death.

To the Funarel Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29d. Date sigged (Mgnth, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who 12 740MLS 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Box 68760.

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Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Chaney, Jr. Richard Jesse 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) 6. Sex 1X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 85 Yrs July 15 1921 Director Maryland 577-20-3640 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits \*ou\* rthen "neturel", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13514 Spring Hill Drive 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "neturel", or item eny injury or other traumatic event, Ita Madical Examinariance. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White Completed by 9/6/1945 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the second comp 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C.P.A. Accounting Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Richard Jesse Chaney, Sr. Grace Virginia Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy P. Chaney (wife)
20a. Method of Disposition 13514 Spring Hill Drive Hagerstown Maryland 21742 e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Green Hill Cemetery 9-9-06 4 ☐Donation 5 ☐ Other (Specify) Waynesboro Pennsylvania 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the buriai-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical for use as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed be should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an hes page 5 2000 this certificete 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 2 R/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the et 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide To the Hospitei Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOO 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) - OAKHIL AVE.

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State Registrar

31. Date filed (Month, Day, Year) 2006

strair's Signature

KIT

			1 - For State Registrar	State of Maryla		artment of rtificate o		nd Menta	al Hygier	- Z U U t	5 29700
	Physici		Decedent's Name (First, Middle, La CARMELO	CANALE:	S			Me		Day 2006	3. Time of Death 8:42P M
	/Medic Examin		4a. Facility Name (If not institution, giver Holy Cross Ho				or Location of	ing		4c. County of Deat Montgo	
	Funeral Director		378-42-0418	ex 7. Age (In y	rs. last birthday) 6 Yrs.	If Under 1 Year Months Day		Min. Au	te of Birth Onth Day Yes	9. Birt 20 P1	hplace (State or Foreign untry) lerto Rico
	Maryland	tor	Usual Residence of Decedent		City, Town or Lo	ver Spi	ring				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23s or 28	Funeral Director	10e. Street and Number 1316 Fenwick	Lane		10f. Zip Code 2 (	910		10g. (	U.S.A.	*
036	72 hours atter death with the Maryland naturel', or iteme 23a or 28a-f ehow disal Examiner must be natilied at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Amged Forces?  1  Yes 2 No 1 If Yes, Give Year or Dates:	945-	Was Decedent of If Yes, specify Co 1 ☐ Yes 2 🕱 N	f Hispanic Orig uban, Mexican, lo Specify:	in? (Specify Your Puerto Rican, uerto	es or No- etc.) Rican	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or iteme 23s or 28s-f show early injury or properties of the Waddesi Examiner must be notified at once.	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1.2+h		(Give	dent's Usual Occ kind of work doi DO NOT use ret atalog:	ne during most ired)			Kind of Business/ Library Congre	of
yland	ould be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last,  Julio Cana				į	r's Name <i>(First</i> Luisa		<sub>en Sumame)</sub> ielo Gai	cia
, Mar	and 2 sho alth and 127 le m		19a. Informant's Name/Relationship ( Emerita Canale			•				y or Town, State, 2 ing, MI	
Baltimore,	ant of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cre	osition (Name of matory or other p nrl Sve		Date /3 /2 0 (		Location - City or	
Balti	permit. P Departm Importer eny injuu		21. Signature of Funeral Service Licer	The second secon	// 2	2. Name and Add	dress of Facility	Snow	den Fu	nerla F	Home, PA e, MD20850
	Physician		23a. Part1. Enter the dispase, or com shock, or heart fairupe. List only Immediate Cause (Final disease or condition	plications that caused the done cause on each line.  Asyptol	eath. Do not en						Approximate Interval Between Onset and Death
	/Medical Examiner	J.	resulting in death)  Sequentially list conditions,	b. Multi O	rgan F	ailure					
Ξ	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Sepsis Due to (or as a cons							
8760,	icate be executed physicien and s the burial-transit	edical Ex		Pneumon							
P.O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3[	□Ectopic pregnal				23d. Date of del Month	ivery Day Year
	sign Sign 1 be	হ	Part II. Other significant conditions (	ontributing to death but not	resulting in the u	inderlying cause	given in Part I.	2:	3e. Did tobacc		othe cause of death?
of Vital Records,	The law ate has b page 2 s	Completed							4a. Was an autopsy performed′	prior to death?	itopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			)thor	of Death (Che			
ion of	ding After fune	ation: To	1 ☐ Yes	28a. Date of Injury (Month, Day Year	28b. Time of Injury	of 28c. In	4 🗆 1401	28d. D	☐ Residence escribe how in	6 ☐ Other (Specially occurred	cify)
Division	al or Attendes safter death	Certification:	3 Suicide 6 Could not b	28e. Place of Injury - A building, etc. (Sp.		reet, factory, office	Э		cation (Street ty or Town, St		ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (		nysician: To the best of my niner: On the basis of exam and manner stated.							
	To the To the complet	Me	29b. Signature and title of certifier	NA.			4100			Date signed (Mont	
•	٣		30. Name and address of person who Smitha, Bhikk		Item 23a) (Type,	Print)		Silve		ing, MD	
	Sta , Regist		31. Date filed (Month, Day, Year)						_ ~	,	

			For State Registrar	State of Mai	ryland / Depa		lealth and Me	•	ene 2008	2970
	Physici	an	1. Decedent's Name (First, Middle, Lass	у Ј.	-	Cashman		2. Date of Death August 29	2006ar	3. Time of Death 17:57 Р м
	/Medic Examir	al	Kimberlee  4a. Facility Name (If not institution, give 4511 Romlom Street	street and number)			r Location of Death	August 2.	4c. County of Deat Prince Ge	th
	Funeral Director		Social Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, Y Jan. 31, 1	9. Birt 958 Mar	hplace (State or Foreign
	Maryland fed at	tor	Usual Residence of Decedent  10a. State  Maryland  Prince Ge		10c. City, Town or Lo Beltsvill	Le				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28a at be notifi	Funeral Director	10e. Street and Number 4511 Romlon Stree	t, #304		10f. Zip Code	0705	10g	Citizen of What Co	ountry? ites
920	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow envi injury or other traumatic event, the Modical Examinat must be notified at once.	by Funer	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify:	
15-0	n 72 ho r *natur	leted	15. Decedent's Edi (Specify only highest grad	ie completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of workin d)	9	b. Kind of Business	
212	ed withi	Completed	Elementary/Secondary (1-12)	College (1-4or 5+	Clerk			D	istrict F	hoto
Maryland 21215-0036	ould be fill Mental Hy arked oth	To Be	James J. Cashman,				18. Mother's Name Barbara S	trausbur	'g	
Mar	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (7) Diane M. Costello		196. Maili 4509	ng Address <i>(Street</i> Yucca St	and Number or Rural reet Belts	Route Number, C Ville, M	ity or Town, State, 2 laryland 2	Zip Code) 20705
Baltimore,	ges 1 a		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cre		l l		c. Location - City or	
altim	mit. Pa partmen portant: / injury		4 □Donation 5 □Other (Specify, 21. Signature of Funeral Service Licens				atory 8/31 Bafawardt			
ä	P P E G		23a. Part1. Enter the disease, or comp	Bogwa						ryland20705
	Pnysician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line aCardiac	Arry thmia		ig, such as cardiac of	respiratory arrest	,	Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for as a	cons duence of					
3760,	ate be executed hysicien and the burial-transit	ca	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
P.O. Box 68	The law requires that the death certificate be executed ate been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy	1		23d. Date of del Month	ivery Day Year
rds, P.	quires that en signed by uld be deta	र्व	Part II. Other significant conditions co Chronic Renal Fai		not resulting in the u	inderlying cau <i>s</i> e giv	en in Part I.	23e. Did tobac	V	the cause of death?
Division of Vital Records,	The law requate hes been are page 2 should	Completed						24a. Was an autopsy performer	prior to	utopsy findings available completion of cause of
Vita	sician: certitic rector.	Be	25. Was case referred to medical examiner?	Hospital:	• • • • • • • • • • • • • • • • • • •	ot 3C DOA Oth	26. Place of Death			
on of	nding Phy th. : After this funeral d	ıtlon: To	1 Yes 2 No  27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ER/Outpatier 28b. Time o Year) Injury	f 28c. Injur Wor	4 Li Nursing nom	8d. Describe how	e 6 Other (Specinjury occurred	city)
Divisi	al or Atter s atter dea if Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, farm, st (Specify)	reet, factory, office	2	Bf. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	To the Hoepital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medicai C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of iner: On the basis of e and manner state	xamination and/or in	h occurred at the tire evestigation, in my o	ne, date and place, ar pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	withir To th	Me	29b. Signature and tift of certifier	2 Sig	l	29c. Licens D4566		29d.	Date signed (Mont. August 3	
	4		30. Name and address of person who of Dpinder Singh, M.I	ompleted cause of deal.	ath (Item 23a) (Type,	Print) Lane,#12	24 Bowie,	Maryland	20715	

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

0 5 2006

			For State	State of Maryland / Dep		lental Hygien	°2006	29702
			Registrar		ertificate of Death	Reg. N	. 2000	3. Time of Death
	Physicia	ın	1. Decedent's Name (First, Middle, Last	Conec			ay Year	0441 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		c. County of Death	
			RAINARA REGISTAL M	Hedral Center	Salisburg		Wian	
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last birthday  Yrs.  Yrs.	Months Days Hour Min.	8. Date of Birth (Month, Day, Yea	r) 9. Birth	place (State or Foreign intry)
	ס		Usual Residence of Decedent			/-2-5	7	VA
	arylan show	٦	10a. State 10b. County	10c. City, Town or I	Location			10d. Inside City Limits  1 ✓ Yes 2 ☐ No
	the Mi	ecto	10e, Street and Number	ter rocom	10f. Zip Code	10a C	Citizen of What Cou	
	3a or		812 - Secons	d Street	21851		11.5.1	1
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amen Black, White,	
36	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow La Medigal Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	lack
5-0036	2 hou	ted	15. Decedent's Edu	cation 16a. Dec	edent's Usual Occupation re kind of work done during most of work		Kind of Business/Ir	ndustry
7	within 7 iene. then "n	Completed	(Specify only highest grad		DO NOT use retired)	" 41	S (Or	struction
121	filed w Hygier Ather th		17. Father's Name (First, Middle, Last)	ttea	18. Mother's Name	(First, Middle, Maide	an Sumame)	C/~
an	ould be Mental Marked o	To Be	Palestine	Copes	mari	on M	ilhour	۸۰,
Maryland	and and sm	-	19a. Informant's Name/Relationship (T		iling Address (Street and Number or Rura	al Route Number, City	or Town, State, Zi	o Code) 2/85/
	1 and 2 Health em 27 i		Marion Milbou	20b. Place of Disp	- Je word Stre	Date 20c.	Location - City or T	ityped.
nor	nt of h		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	rematory or other place)	Δ( II)	25 / Constant	en d
Baltimore	permit. Pages Department of Important: If I eny injury or once.		21. Signa ure of Funeral Service Licens	- MULCOW	22. Name and Address of Facility	envic Sa	with Fre	soral Han
ä	Departiment Department		Moule	Suren 1	P.O. BUX371	oconoko	City	nd. 2181
			shock, or heart failure. List only of			or respiratory arrest,	/	Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a consequence of):	CVD		-	1
	Examiner			bus to tot as a consequence or,				
	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or as a consequence of):				
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
8760	icate be executed physician and s the burial-transit	dicai E		d				
9	ntificating physics as the	Medi	IF FEMALE:					
Вох	the death certific y the ettending p iched for use as i	lan/l	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
P.O.	the d y the	Jysic	1 Yes 2 No 9 Unknown	9 Unknown	Cities (specify)			
	w requires that been signed b should be deta	Completed by Physician/Me	Part II. Other significant conditions co	ntnbuting to death but not resulting in the	underlying cause given in Part I.			the cause of death?
ord	require een si oould I	ted				1 Tyes		babiy 4 Unknown
Records,	e la hes je 2	mpie				24a. Was an autopsy performed?	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
E	ician: The posteriticate herector, page	ဝင္ပ	25. Was case referred to medical		26 Place of Deat	1 Yes 2X		2 □ No
f Vi	S 5	To B	examiner?	Hospital: 1 Inpatient 2 ER/Outpati	Other	me 5 Residence	6 ☐Other (Spec	ify)
0	E E	ou:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how in	ury occurred	
Division of Vital	death. ctor: A y the fu	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f. Location (Street	and Number or Rui	ral Route Number,
Ο̈́	s after s after s of in b	Certification:	4 Homicide determined	building, etc. (Specify)	,	City or Town, Sta	te)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		(Check only 2 Medical Exam	vsician: To the best of my knowledge, de iner: On the basis of examination and/or				
	thin 24 the Formplet	Medicai	29b. Signature and tyle of certifier	and manner stated.	29c. License number	29d. D	Date signed (Month,	, Day, Year)
	To To		* ( Aul		1450497	9	15/06	
			· ·	ompleted cause of death (Item 23a) (Typ	e, Print)			
	BA 2		CHNS SNUQUE 31. Date filed (Month, Day, Year)	160 E. CANON ST.	SAUSBURG.	NG		
	Sta Regist		SEP 0 6 20	06 the to A	29c. License number 1450497 e, Print) SAUSBURG			

PAVESTINE CAPSHELL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 12,2006 **Physician** 5:46P Charles William Callender, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital of Baltimore N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 1-1-1921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 ☑ M 2 □ F 215-09-1440 85 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State a filed within 72 hous w... al Hygiene. 3 other than "natural, or items 23a or 28a-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3500 Old Trail 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookbinder Printing ulth and Menta! Hygie 27 is marked other! r treumatic event, II permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygh important: if tiem 2.7 ie marked eny injury or other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Eugene Callender Margaret W. Hamill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katherine M. Callender/ Wife 3500 Old Trail, Edgewater, MD 21037 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery | 9-18-06 Crownsville, MD 21. Signature uneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this After thi 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the state of 29c. License number 29b. Signature and title of certifier ES 000 fed cause of death (Item 23a) (Type, Print) 30 Name and address of person who comb 3 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 8 2006 Registrar

			,	State of Maryland / Department of Hea  1- State Registrar Certificate of De	alth and Me	ental Hygie	ne 2006	29704
				1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day / A Year	3. Time of Death
		Physici /Medic		Harold Davidson	/	August	31, 2006	4:06AM
		Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc	cation of Death		4c. County of Death	
		Funeral			Under 24 Hrs.	8. Date of Birth	PG . 9. Birthpl	ace (State or Foreign
		Director		359-26-3239   1 x 2 F 71   Yrs.   Months Days H	Hours Min.	8. Date of Birth (Month, Day, Y June 14	,1935 Ill	ry) •
		pug M		Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or Location				d. Inside City Limits
		Mary!	tor	Md PG Largo				Yes 2□No
		deeth with the Maryland	Director	10e. Street and Number 10f. Zip Code		10g	. Citizen of What Coun	ry?
$\geq$		23a c	ral D	10237 Campus Way South 20774			USA	
20		er de Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2X2No	anic Origin? (Spec Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	etc.
7	920	urs aff	b	If Yes, Give 1 ☐ Yes 2 ▼ No S  3 ☐ Widowed 4 1 ☐ Divorced Year or Dates:	Specify:		SpecifyBlac	K
AVIDSON	21215-0036	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	on ing most of workin	ng 16	b. Kind of Business/Ind	ustry
JA	121	within ane. than "	mp	Elementary/Secondary (0-12)   College (1-4or 5+)	ficer		Dept of	The Navv
V	d 2	Hygie Hygie other				(First, Middle, Ma	<del>-</del>	
K	lan	Aental Aental rked tic ev	To Be	James Davidson L	illian	Davis		
arola	Maryland	2 shor		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and				
2	6,	tealth tealth im 27 ther tr		Liletha Davidson (daughter) 10237 Cam  20a. Method of Disposition (Name of			Largo, Md	
4	nor	nt of h		1 Burial 2 Coremation 3 Removal from State Pitzondal of Plance	00 00		verdale	
`	Baltimore,	permit. Pages 1 end 2 should be tiled within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Madical Examiner must be notified at ODGE.		21. Signatur Funeral Privice Licensee 22. Name and Address of	of Facility		Wash D	
	ä	Deg E G		Sylone / Jaune / Tyrone J. J	_		-	Wr.
	760,	Physician /Medical Examiner partial lianual partial pa	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, si shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	U CEPAL ENAC	DI	This SEASE	Approximate Interval Between Onset and Death
	P.O. Box 68	The law requires that the death certificate be executed the has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown			23d. Date of delive Month	ry Day Year
		uires that signed b ild be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
	900	aw requir is been si 2 should l	Completed			24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
	R	The law sete has page 2 :	Com			performe	death? 1 ☐ Yes	
	Vita	icien: certific ector,	Be	examiner?		(Check only one)		
	of	Phys r this ral dir	5	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	4   Nursing Hon	ne 5 Resident 28d. Describe how	ce 6 Other (Specify injury occurred	)
	ion	nding ath. r: Alte e fune	atior	2 ☐ Accident investigation M 1 ☐ Yes	s 2 No			
	Division of Vital Records,	or Attender des Directo in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stre City or Town,	et and Number or Rura State)	Route Number,
	ū	To the Hospitel or Attending Physicien: The I when 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Ce	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner stated.				
		To the	Me	29b. Signature and title of certifier 29c. License nu			I. Date signed (Month,	,
		((10)		$C \rightarrow DS$	818	2 5	eptember	-1, 2006
		De	+	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ce Cil Di George 7305 A Honover Parkw	ay , Gr	eenhelt	mD. 20	-1, 2006 770
		St Regist	ate rar	31. Date filed (Month, Day, Year)  SEP 0 7 2006	, ,	-		

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Tandong Johnson Efuet 1- For State

Certificate of Death

2006 29705

Physicia			ate of Death		3. Time of Death					
Medical Exami		TANDONG JOHNSON EFUET A	nonth Day	y Year 006	1528 hrs					
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Silverspring		4c. County of Death Montgomery						
Funeral Director	Ĺ	218-75-9/54   1 X M 2 F   27 Yrs.   World S   Says   100/15   100/	Date of 8irth(MI OCTOBER	M/DD/YYYY) 9. Birtl 12 1978 Col	Polace (State or FOMTEM CAMEROON, WA					
any	_ <u> </u>	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location	<u></u>		10d. Inside City Limits					
ž .	_	MD PRINCE GEORGE'S HYATTSVILLE			1 X Yes 2 No					
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code 20783		itizen of What Coun	try?					
th with th ems 23a t be notil	era	11. Marital Status  12. Was Decedent Ever in U.S  13. Was Decedent of Hispanic Origin? (Specify IX Never Married 2 Married Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica		14. Race - Americ White, etc.	can Indian, Black,					
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sh al Examiner must be notified at once	by Fun	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify:	Lo		ACK					
11215-0036 Id be filed within 72 hours a fental Hygiene. narked other than "naturs event, the Medical Exami	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)		b. Kind of Business/Ir	ndustry					
15-0036 filed within 72 I Hygiene. d other than "t, the Medical I		12th STUDENT  17 Father's Name (First Middle, Last)  18 Mother's Name (First N		N/A						
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than atic event, the Medica	Be	LAWRENCE TANGDONG FUET SUSANA	ALEON	GU						
	٩	19a. Informant's Name/Relationship (Type, Print )  GEORGE TANDONG FUET/BRO.  19b. Mailing Address (Street and Number or Rural 5700 SILK TREE DR RIVER)			Zip Code) 0737					
Malth 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location									
OFF Tages 1 The High History of the recognition o	202. Method of Disposition  1 X Burial 2 Cremation 3 X Removal from State  FAMILY PLOT  202. Name and Address of Facility J. B. JENKINS  203. Place of Disposition (Name of Called System)  1 X Burial 2 Cremation 3 X Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility J. B. JENKINS									
Baltimo permit. Page Department o Important: injury or oth	INS FUNERA	AL HOME								
		K.D.M-Lall 7474 LANDOVER ROAD I								
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restallure. List only one cause on each line.	spiratory arrest, s	shock, or heart	Approximate Interval Between Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):								
	Jer	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):								
d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):								
760, cate be executed physician and the burial - transit	lical E	d. UNPENDED AMENDED								
68 ertifi ding	Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  23c If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown		23d Date of delivery Month D	ay Year					
F.O. E ires that the case signed by the detached	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to	the cause of death?					
cords law requestable has been	Completed		24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of					
tal Recicion: The certificate	യി	25. Was case referred to medical 26. Place of Death (Check only		- [,						
Vita hysici this o	To B	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Ho		sidence 6 🗸 Other	Scene					
on of vending Phath.  on: After the funeral	S 1 Natural 5 Pedestrian struck by auto									
Divisior  Hospital or Attene 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined determined (Specific Major Read / Highway)	or Town, State		ral Route Number, City					
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide 1990 Road / Fightway Road / Fightwa	e to the cause(s)	and manner as start	ed.					
To the within 2 To the complet	Medical	and manner stated  29b. Signature and title of certifier  29c. License number		d. Date signed (Mor						
	_	Mhan Ar arre a Mid	A	august 31, 2006						
12		30. Nam. and address of person who completed cause of death (Item 23a)								
Off)		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201							
S Regis	tate trar	31. Date filed (Month, Day, Year)  SEP 0 6 2005  Registrar's Signature								

State of Maryland / Department of Health and Mental Hygiene 29706 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** LOUIS EGGLESTON SEPTEMBER 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE MAGNOLIA HEALTH CENTER LANHAM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1. M 2□ F NEW YORK 83 123-16-8793 Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a, State 10b. County ral', or items 23a or 28e-f show Example must be notified at 1X Yes 2 No Director MD PRINCE GEORGE LANHAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 U. S. A. 9006 WALLACE ROAD Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X X es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: BLACK 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) N 1 H SAFETY COORDINATOR 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be EGGLESTON MASON PORTER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If itsm 27 is any injury or other trau 9DC8. LANHAM, MD 20706 9006 WALLACE ROAD VIRGINIA H. EGGLESTON--WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN MEMO. CEMETERY 9-8-06 SUITLAND, MD \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HUME 21. Signature of Funeral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002 Do of ententhe mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** Zweek /Medical BONFL OBSTRUCTION Examiner weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 1 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗹 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 24 hours after deat Funeref Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide in by 4 Homicide pellil To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the 29d. Date signed (Month, Day, Year) 29b. Signalui title of ce Mie 018 of death (Item 23a) (Type, Print) sensbury Rd Hyattsville Mis 20781 31. Date filed (Month, Day, Year) State Registrar

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Elmendort, william

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Charles Allen Fortune Certificate of Death Reg No 1- For State 2 Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day August 26, 2006 0242 hrs Physician/ Jr. Fortune Α. Charles **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number oreign Country)Wash.D.¢ Dec.9,1970 Hours **Funeral** 35 579-06-1928 **X** M 2 Director 10d. Inside City Limits Usual Residence of Decedent Oc. City, Town or Location 10a, State 1 XYes 2 No Riverdale Prince Georges s 23a or 28a-f show notified at once. imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland ner of Health and Mental Hygiene aren of Health and Mental Hygiene in the Maryland in a state of the s 10g. Citizen of What Country? Director 10f, Zip Code 10e Street and Number U.S.A. 20737 Ave. 63rd 5503 14. Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Married Yes Specify Black 1 Yes 2X No specify If Yes, Give Year Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done δ 15. Decedent's Education (Specify only highest grade completed) during most of working life DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) private Inventory 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Washington Margaret Fortune Α. Charles Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print ) 5503 63rd Ave.Riverdale, MD 20737 Margaret L. Fortune-Mother Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition MD. Nat I Mem. Park Laurel, MD 9 - 2 - 06₩Burial 2 Cremation 3 Removal from State Important: I injury or oth Department Donation 5 Other Specify 22. Name and Address of Facility Hunt Funeral Home Signature of Funeral Service License 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death a Multiple Injuries /Medical Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED ing physician a as the burial -23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Day 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I igned by t o Yes 2 No 3 Probably 4 Unknown \$ ۵ 24b. Were autopsy findings available Completed Division of Vital Records, prior to completion of cause of autopsy performed? death? has ✓ Yes 2 No 1 🗸 Yes 2 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Other<sub>4</sub> Be Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 2 1 🗸 Yes 28c. Injury at Work 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury motorcyclist struck fixed object 27. Manner of Death After Aug 25, 2006 Certification: 2146 hrs Yes 2 🗸 No Natural 5 Pending 24 hours after death Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Route 202 ramp to Route 214, Largo, MD 6 Could not be Suicide (Specify) Major Road / Highway determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 29a Certifier 1 2 W Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the one) and manner stated. 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi August 26, 2006 O.C.M.E

State

Margarita Korell MD. 31. Date filed (Month, 2006

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 32. Registrar's Signature

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

Registrar

			1 - For State Registrar	State of Maryl	-	artment of Healt <i>tificate of Dea</i>	h and Mental Hy eth		23103
4			Decedent's Name (First, Middle, La.	st)			2. Date of De		3. Time of Death
1	Physici /Medic		Alice Fotz	naer			Month	Day Year	09:40 M
	Examin		4a. Facility Name (If not institution, giv	street and number)		4b. City, Town, or Locati	ion of Death	4c. County of Death	ON.
				Juma Cen	ter	Faltimore		Baltime	one CITY
	Funeral		5. Social Security Number 6. S 174–10–4414	ex 7. Age (In. 9	yrs. last birthday)  7 Yrs.	If Under 1 Year If Un Months Days Hou		rth 9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent		J		April	20, 1913 P∈	ennsylvania
	Maryland a-f ehow	ctor	Maryland Anne Ar		. City, Town or Lo		ewater		10d. Inside City Limits 1 ☐ Yes 2X No
	or 28	Oire	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cou	intry?
	ath w	rai	411 Hamlet Club D			210		U.S.A.	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. of other then "neture!; or iteme 23s or 28s-f show event, the Medical Examinar court be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic f Yes, specify Cuban, Mex I□ Yes <b>2827</b> No <i>Spe</i>	c Origin? (Specify Yes or Nocican, Puerto Rican, etc.)  cify:		
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	lent's Usual Occupation kind of work done during i DO NOT use retired)	most of working	16b. Kind of Business/li	ndustry
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42	filed v Hygie other t	ပိ	12 17. Father's Name (First, Middle, Last)		rac	tory Worker	lother's Name (First, Middle	Electro	nics
an	Mental Merked o	To Be	Frederick Shivel			i _	na Long	.,,	
<u></u>	2 should be and Menta is marked aumatic ev	Ĕ	19a. Informant's Name/Relationship (	Гуре, Print)	19b. Mailir	g Address (Street and Nu	ımber or Rural Route Numb	ber, City or Town, State, Zi	p Code)
	ath a		Walter Fatzinge	r/son	3452	Constellatio	on Drive Dav	idsonville,	MD 21035
ore,	jes 1 ar of Hea of item or other		20a. Method of Disposition  1  Burial 2	Pomoval from State	b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or T	own, State
Ē	nit. Pages vartment of ortent: if it injury or o		4 □ Donation 5 □ Other (Specif		Baltimor	e Crematory		Baltimore,	
Baltimore,	permit, Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licer	Till	w 1.	Name and Address of Fa Name and Address of Fa	<sup>acılity</sup> John M. T Gloucester St	aylor Funera ., Annapolis	1 Home , MD 21401
	Z.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of dying, such	n as cardiac or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Traum	atic F	Sain Ini	uru Gubo	highway	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):		of Hem	onhan	
	ZXGIIIIII	16	Sequentially list conditions,	b. Due to (or as a cor	Tylul	N		27	
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (01 as a cor	isequence oup	9	a	D A MA	
	tificate be executed ig physician and as tha burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a cor	nsequence of):			CAL STANCE	
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99	tificat ng phy as th					-	W PON		
P.O. Box	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as tha buriat-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of print   1 Live birth   2   1   4   Pregnant at time   9   Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	Control of the Contro	23d. Date of deliv Month	r <b>ery</b> Day Year
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010	w require been signationships	eted	Congestive	1 10011	'CITO				
of Vital Records,	ysician: The law is certificate has b director, page 2 s	Completed by					24a. Was auto perf 1 \( \text{Yes}	opsy prior to coormed? death?	opsy findings available ompletion of cause of 2 No
Vit.	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death Check only		
o	Phys r this sral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien	I 3 DOA   4L	Nursing Home 5 Res	how injury occurred	fy)
on	ding th. : Afte	tion	1 □Natural 5 □ Pending 2 ▼Accident investigatio	(Month, Day Yea	(1) \7.30	28c. Injury at Work?  M 1 Yes	1	a.m cellar	stairs
Division	Atter	ifice	3 Suicide 6 Could not b	e 28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office	28f. Location (	(Street and Number or Rui own, State)	
	s afte	Certification:	4 Dillomode	building, etc. (3)	OF hor	ne	34520	onstellation D	1751/050UVI
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exer	nysicien: To the best of my niner: On the basis of exa- and manner stated.	knowledge, death mination and/or in	n occurred at the time, dativestigation, in my opinion,	e and place, and due to the death occurred at the time	cause(s) and manner as date and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title ol certifier			29c. License numb	ber	29d. Date signed (Month)	Day, Year)
	- > - 0		Kantia	CM		17:	516	8-28-6	200
•			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	516 Baltimore	000	
_			Kim Castr	0 225	, Gree	ne St 3	Baltimore	MD	
1	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 1	2006 32. Proistrar's S	Signature	book			

			For State Ragistrar	State of Ma	ryland / Da )	epartment of He Certificate of D	ealth and M Death	lental Hygi 80	ene 2006	5 29710
1.00			Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	<del>-</del>	3. Time of Death
	Physicia /Medic		Edward Palmer FO	)RD				SEPTEMBER	- 06 2006	11:40 AM
) .	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or l	ocation of Death		4c. County of Dea	ath
	, i		Western Maryland Hosp			Hagerstown	W. ( )		Washington	
	Funeral		Social Security Number     6. S	ex 7.Age X∏M 2□F	(In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
19.00	Director		219-14-7932 Usual Residence of Decedent		82 <sup>Y</sup>			Jan. 23	1924 Wes	st Virginia
	land ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary -1 sh	to	Maryland Washing	ton	Hager	ctown				1X Yes 2 □ No
	1 the	Director	10e. Street and Number	<u>, LOII</u>	nager	10f. Zip Code		10	g. Citizen of What C	ountry?
	h with		369-A Nottingham	Road		21740	)		USA	
	deatl	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of His If Yes, specify Cuban		ecrfy Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
ထွ	or the	F	1 ☐ Never Married 2 Married	1 X Yes 2 □ N II Yes, Give	lo	1 ☐ Yes 2X No	Specify:	,,	Specify:	10, 010.
2-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-t show aumatic event, the Madical Exams art must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	WW II	_			W	hite
Ϋ́	nation	Completed	15. Decedent's E (Specify only highest gra	ducation de completed)		Decedent's Usual Occupat (Give kind of work done du life, DO NOT use retired)	uring most of work	ing 1	6b. Kind of Business	s/industry
2121	within ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5	+)	nsultant		C	and Blast	Mfa
0 0	Hygie Hygie Sther of the	e Cc	17. Father's Name (First, Middle, Last		1 00.		18. Mother's Name			ritg.
an	Mental Merked of	<b>m</b>	Samuel Ralph Ford	1			Zeluska	Palmer		
Maryland	shoul nd Ma mari	욘	19a. Informant's Name/Relationship (		19b.	Mailing Address (Street at	nd Number or Rura	al Route Number,	City or Town, State,	Zip Code)
_	nd 2 alth a 27 ls		Winifred E. Ford	- Wife	36	9-A Nottingh	am Road,	Hagerst	own, Md.	21740
ē,	s 1 a of Hei Item		20a. Method of Disposition		20b. Place of cemetery	Disposition (Name of crematory or other place		Date 2	toc. Location - City o	r Town, State
E	Page nent c int: If		1 🔀 Burial 2 🗍 Cremation 3 🖟 4 ☐ Donation 5 ☐ Other (Speci		Cedar L	awn Mem. Par	k Sept.	8 2006	Hagersto	wn. Md.
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic en <u>ance.</u>		21. Signature of Funeral Service Lice	nsee n	/	22. Name and Address			uneral Ho	
<u> </u>	825 2 3		19000	11/01/0	ma	415 E. Wil	lson B1vd	., Hager	stown, Md	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do no	ot enter the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
j.	Physician		Immediate Cause (Final disease or condition							1/2 YEARS
2004	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	f):				
	* *	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as:	a consequence o	d).				
	ted nsit	nln	cause. Enter Underlying Cause (Disease or injury		,					
<u>,</u>	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence o	f):				
68760,	ysicia ysicia	dical	(	d						
			IF FEMALE:							
Вох	death certifi le attending   ed for use as	an/h	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	of pregnancy 2 Fetal death	3 Ectopic pregnancy			23d. Date of do Month	elivery Day Year
Ö.	0 0	Physician/M	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 Other (specify)				22,
P.O.	that the de led by the a detached t	F.	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	8 P 8	d by	MALNUTRITI	_		, ., ., .,		1	s 2. <b>X</b> No 3□F	Probably 4 Unknown
Ö	w requir been si should l	ete	DEEP VEIN TH					24a. Was ar	24b. Were a	autopsy findings available
Rec	he lav e has ige 2	Completed	DEEP VEITO IT	RUM 190513				autops	y prior to ned? death?	completion of cause of
a	in: Ti ificate or, pa	e Cc	25. Was case referred to medical				26 Place of Deat	1 Yes 2		s 2 No
5	Physician: r this certificant ral director,	To B	examiner? 1 ☐ Yes 2 ② (No	Hospital: 1 ☐ Inpatie	ont 2 ☐ ER/Out	tpatient 3 DOA Othe			nce 6 □Other (Sp	ecify)
10	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. T	ime of 28c. Injury	- 23	28d. Describe ho		
ior	ath. or: Aft	atlo	1 Natural 5 Pending 2 Accident Investigation	in	, , , , , , , , , , , , , , , , , , , ,		res 2□No			
Division of Vital Records,	or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not t 4 Homicide determined			rm, street, factory, office		28f. Locetion (Sta City or Town	reet and Number or F , State)	Rural Route Number,
Ω	urs al		CO- CVine 17 Continue B	business To the boot	of my ke awledge	double accurred at the time	e data and place	and due to the en		no atata d
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edical			examination and	, death occurred at the time d/or investigation, in my op				
	To th within To th compl	Me	29b. Signature and title of certifier	. 4 .		29c. License			9d. Date signed (Mor	nth, Dey, Year)
			> mul	7 MD		D 00	62895	2	SEPTEMBE	R, 06, 2006
			30. Name and address of person who			Type, Print) 1500 Pe	ennsylvania			, , , , , , , , , , , , , , , , , , , ,
2	H-5+1		31. Date filed (Month, Dey,-Year)	E DAL	EY	Hagers	town, MD 21	742		
	St Regist	ate rar	31. Date filed (Month, Dey,-Year) SEP 0 7	2006 32. Registr	ai s Signature	Spell				
72	1 1 1 m	N	JEF V I	respec	¥	. /				

SOWAS THUMBS

			For State Registrar	Si	tate of N	Marylan	d / Depa <i>Cei</i>	artmer <i>tificat</i>	t of H e of L	ealth a D <i>eath</i>	and M	ental Hyg	iene g. No. 200	16	29712
	Dhuciai	20	1. Decedent's Name (First, Middle	, Last)								2. Date of Deat Month		ear	3. Time of Death
	Physici /Medic		Lillie Mae	e Gra	ay							Septemb		06	6:45 p. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution	_		or)				Location o	of Death		4c. County of I		
			213 Virginia 5. Social Security Number	Avenu		Age (In ure	last birthday)		ambri 1 Year	Idge	24 Hrs.	8. Date of Birth			ster ce (State or Foreign
	Funeral Director			1 □ M		54	Yrs.	Months	Days	Hours	Min.	(Month, Day,	0, 1952	Country	yland
			216-64-8397 Usual Residence of Decedent			54						March	0, 1932	LIGIT	yranu
	yland	. [	10a. State 10b. County			10c. Cit	y, Town or Lo	cation						100	d. Inside City Limits
_	Sa-1-	cto	MD Do:	chest	er				Can	bridg	ge				1 Myes 2 No
3	72 hours after death with the Maryland naturel', or items 23e or 28e-f ehow disal Exaction must be notified at	by Funeral Director	10e. Street and Number	λιτοι	2110			10f. Zij	Code	21	1613	1	0g. Citizen of Wha USA	t Countr	y?
3	s 23e	rai	213 Virginia		Was Decede	nt Ever in II	S 12.5	Mac Deco	dont of Hi			city Vac or No-	14. Race -	America	n Indian
_	iter de	Fun	11. Marital Status  1 □ Never Married 2 Mar	1	Armed Force	s?					i, Puerto I	cify Yes or No- Rican, etc.)		White, et	
99	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 1	If Yes, Give Year or Date:			1 🗌 Yes	2 <b>⊠</b> No	Specify:			Specify:	whi	te
ģ	72 ho	Completed	15. Deceder (Specify only highe	r's Education	on mpleted)		16a. Dece	dent's Usu	al Decupa	ation during most	t of worki	70	16b. Kind of Busin	ess/Indu	istry
2	ithin	nple	Elementary/Secondary (0-12)	~	College (1-4c	or 5+)	life.	DO NOT u	se retired nemak	)			own h	omo	
2	led w lygier her th		10 17. Father's Name (First, Middle,	( 004)				TIO	lellar		de Nama	(First Middle A	Maiden Sumame)	Jue	
and	ntai F od ot	Be			. ~								walderi Sumame)		
Ž	hould Mark mark matic	ပ္	William S.  19a. Informant's Name/Relations				19b. Mailir	na Addres	(Street a			Mills  I Route Number	City or Town, Sta	ite, Zip (	Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examination must be notified at an ance.		John L. Gray		husba	and		•				bridge,			
Baltimore,	S 1 al		20a. Method of Disposition			20b. F	Place of Dispo	sition (Na	me of				20c. Location - Cit		m, State
Ë	Page Nent o nt: if		1 ⊠ Buriai 2 □ Cremation 4 □ Donation 5 □ Other (S		oval from Sta	10	yland			1	9/6	5/06	Hurlock	- MD	
alti	permit. Depertrimports eny inju		21. Signature uneral Service	Licensee	,	10,000	22	2. Name a	nd Addres	s of Facilit	y Th	omas Fu	neral Ho	me P	.A.
<u> </u>	89788		the will	en								Cambridg		1613	
П			23a. Part1. Enter the disease, o shock, or heart failure. List	complication only one complication	ause on each	n line.								1	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a	Ter	Wina	Bi	liar	1 A	tdei	no (	erchi	Me		onsot and boath
	/Medical Examiner		resulting in death)		Due to (or	as a conseq	uence of):		1						
		- e	Sequentially list conditions,	b	Due to (or	as a conseq	uence of).								
	uted J Insit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>S</b>											
Ć.	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last	с	Due to (or	as a conseq	uence of):								
8760,	icate be executed physician and s the burial-transit	Icai		d											
9	The law requires that the death certificate site hes been signed by the attending physpage 2 should be detached for use as the		IF FEMALE:												
Вох	eath certific attending p I for use as i	an/	23b. Was decedent pregnant in the past 12 months?		If yes, outcor 1 Live birth	2 Feta	ıl death 3[	Ectopic p					23d. Date of Month		y Day Year
-	it the dea by the a tached for	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant 9□ Unknowr		leath 5	Other (s	oecify)						
P.O.	that the		Part II. Other significant conditi	ons contrib	uting to deat	h but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did tol	pacco use contribu	ute to the	cause of death?
Records,	uires tha signed Id be de	d by										1 🗆 Ye	es 2 10 3	Proba	bly 4 ∐Unknown
200	w requir been si should	ete										24a. Was a	n 24b. We	re autop:	sy lindings available
Re	The jay ete hes page 2	Completed										autops		r to com th? Yes 2	pletion of cause of
Vital		0	25. Was case referred to medica	ı						26. Place	of Death	1 Yes	T	105 2	
Ž	S 0 0	To B	examiner? 1 ☐ Yes 2 ☐ Mo	Hosp	oital: 1 🗌 Inpa	atient 2	ER/Outpatie	nt 3 D	Oa Oth	er: 4 🗆 Nu	ırsing Ho	ne 5 Reside	ence 6 Other	(Specify)	
n of			27. Manner of Death 1. □Natural 5 □ Pendi	2	28a. Date of I (Month,	njury Day Ye <i>ar)</i>	28b. Time of Injury	ıf	28c. Injun Wor	y at k?		28d. Describe ho	ow injury occurred		
sio	e e e e e e e e e e e e e e e e e e e	cati		gation				М		Yes 2 🔲	-				
Division	i or Att efter d Direct d in by	Certification:	4 Homicide determ		28e. Place of building,	Injury - At h etc. (Special	ome, farm, st fy)	reet, facto	y, office			City or Town	treet and Number n, State)	or Rural .	Houte Number,
	Hospital or 24 hours efte Funerel Dir tely filled in		29a. Certifier 1 Certifyi	na Physici	an: To the be	est of my kno	wledne deat	h occurre	at the tin	ne date an	nd place.	and due to the c	ause(s) and mann	er as sta	ted
	To the Hospital or A within 24 hours efter To the Funerel Direct completely filled in b	Medicai				s of examina							ate and place, and		
	within 2 To the	₩.	29b. Signature and title of certifi	Pacil	MD			29	c. Licens	e number		2	9d. Date signed (/		ay, Year)
			1 Jaley	1	1.9				047	924			9.5-	06	
			30. Name and address of person				n 23a) (Type,			1100	100	0 - 1 -0	A 2//	10	
				JNW Y	300	- , -		57	C. Y	MISIC	1161	= ,50/	1) 216	15	
	St: Regist	ate rar	31. Date filed (Month, Day, Year SEP 0	6 2000	5	istrar's Signa	B. A	Local							

06-06353 Cynthia Gray Please Type or Print in Black Indelible Ink

Physician/	Re 1.	For State Certificate of Decedent's Name (First, Middle, Last)  Cynthia D Gray		2. Date of Death		3. Time of Death 0005 hrs
al Examiner	48	Prince George's Hospital Center C	ity, Town, or Location of D		4c. County of Death Prince George (MM/DD/YYYY) 9. Bit	e's
Funeral Director		Cociai occurs, itemae	Under 1 Year If Under 2 Ionths Days Hours	Min. 02/15/	/1000 Foreign	
Maryland 28a-f show any d at once.	10	Da. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once. eral Director		1 46th Street S E #21	f. Zip Code 20019  cedent of Hispanic Origin		g. Citizen of What Cou	
s after death rall, or ite	Ľ	X Never Married 2 Married Armed Forces?  1 Yes, Sive Year or pales:  Widowed 4 Divorced (Yes, Give Year or pales):	specify Cuban, Mexican, P  s 2 No specify:  Usual Occupation (Give kin	uerto Rican, etc.)	White, etc.  Specify: Bl2  16b. Kind of Business	ack
ed within 72 hours after bygiene other than "natural", the Medical Examiner Completed by		Elementary/Secondary (0-12)	of working life DO NOT us ent		n/a	
ould be filed within 7 d Mental Hygiene s marked other than fic event, the Medica		7. Father's Name (First, Middle, Last) William Jones 9a Informant's Name/Relationship (Type, Print) 19b. Mailing Ad		thia A Gray	y	e, Zip Code)
permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the injury or other traumatic event, the Med To Be Comp	2	Da Method of Disposition    Serial   2	(Name of cemetery,	Date 09/02/06	20c. Location - City o  Landover	r Town, State
permit. Pages 1 Department of F Important: If injury or other	2	1   Donation 5   Other Specify:  1. Signature of Funeral Service Licensee  Cerry A Austin 382	e and Address of FacilitAt 21 14th Stree	et N W Was	hington D	20011
hysician 'Medical xaminer	1	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the national failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a Multiple Gunshot Wounds  Due to (or as a consequence of).	node of dying, such as care	diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
nsit Examiner		b. Due to (or as a consequence of):				
certificate be execun nding physician and use as the burial - tra		1 Yes 2 No 9 V Unknown 9 Unknown	death 3 Ectopic p	oregnancy	23d. Date of delive Month	Day Year
aw requires as been sign 2 should be	3	Part II. Other significant conditions contributing to death but not resulting in the under the conditions of the conditions contributing to death but not resulting in the under the conditions of the conditions	erlying cause given in Part		an 24b Were a	obably 4 Unknown utopsy findings availab completion of cause of
pital or Attending Physician: The I burns after death.  eral Director: After this certificate if filled in by the funeral director, page	8 3	25 Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital 1 Inpatient 2 ✓ ER/Outpatient 3	26 Place of Death (C		Residence 6 Oth	
ttending Physic death. stor: After this y the funeral dir	- 15	27. Manner of Death  1 Natural 5 Pending 28. Date of Injury 28b. Time of Injury FOWND: Day 24/20060UND: 11  Aug 25, 2006 0138 hrs.	30 pm Yes 2 V	Subject sho		
hou hou		3 Suicide 6 Could not be determined (Specify) Local Street (Specify) Local Street		or Town, S 4639 Bennir	<sup>tate)</sup> ng Road, Washin	
To the How within 24 b To the Fun completely		(Check only 2 Medical Examiner: On the basis of examination and/or investigation and manner stated 29b. Signature and title of certifier	29c. License number	urred at the time, date	and place, and due to	the cause(s)
4	-	30. Name and address of person who completed cause of death (Item 23a)  Pamela Southall, MD Assistant Medical Examiner 111 Per	O.C.M.E.	. MD 21201	August 25, 200	o 
Stat	te	31. Date filed (North Day, Year) 2006 32 Registrar's Signature				

			1 - For State Registrar	State	of Marylar	nd / Depa	artmen rtificat	t of H e of L	ealth a	and Me		giene Reg. No	/ 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	29714
	Physici	e an	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Da	v Year	3. Time of Death
	/Medi	_	Helen		Gildea	1							, 2006	1:30 P M
	Examir	ier	4a. Facility Name (If not institution,		umber)		4b. City,	Town, or	Location of	of Death		4c	. County of Deat	h
٠.	1	*:	Friends Nursing 5. Social Security Number	g Home 6. Sex	7. Age (In yrs	last hirthday)	Sa If Under		Spri	7	8. Date of Bir	ala.	Montgo	
	Funeral Director		236-20-5358	1 □ M 2 🗓 F	84	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	922 WV	hplace (State or Foreign untry)
	ס		Usual Residence of Decedent		04						May Z	2, 1	922 WV	
	inylan ihow		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Ba-f s	cto		tgomery		Silver	Sprin	ng						1 ☐ Yes 2 ŽNo
	dith th	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What Co	untry?
	s 23g	ral	15430 Bramblew			10		2090					JSA	
	hours after death with the Maryland tural', or Itams 23c or 28a-f show at Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed F	cedent Ever in torces?	J.S.   13.	Was Deced	ent of Hi	spanic Orig n, Mexican	gin? (Spec , Puerto R	cify Yes or No tican, etc.)	-	14. Race - Ame Black, White	
21215-0036	urs af	by	3∑Widowed 4 Divorced	If Yes, G	ive		1 🗆 Yes	2 <b>X</b> No	Specify:				Specify: Wh	ite
9	2 hou	ted	15. Decedent	s Education			dent's Usua					16b. K	(ind of Business/	
215	thin 7 9.	ple	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	furing most ')	t of working	g			,
2	ed wi	Completed		4		Budge	t Ana	alyst	:			Fed	deral Go	vernment
nd	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
yla	ould Men Parka	2	Michael Kopson							ry Se				
Maryland	12 sh h and 7 is rr traurr		19a. Informant's Name/Relationsh									_	or Town, State, Z	
	1 and Healt am 2		Barbara Bergman  20a. Method of Disposition	in / nied		12608 Place of Dispo			Court,	, Sil Da	-		ocation - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23c or 28a-f show any injury or other traumatic evant, the Medical Examinat must be notified at once.		1 XXBurial 2 Cremation		n State	cemetery, crei	matory or o	ther place	56	eptembe				
Ē	artme ortani injury		<ul><li>'4 □ Donation 5 □ Other (Sp</li><li>21. Signature of Funeral Service L</li></ul>		Gate	of Heav	<b>7en Cen</b> 2. Name an	#F-05-0-		2006	5	Silv	ver Spring	J, MD
Ba	Dep Impo		A	0-0		F <sub>Y</sub>	rancis	J. Co	olling	Fimera	al Home,	Inc		
	4 1. 7		23a. Part1. Enter the disease, or o	complications that	caus he dea	th. Do not ent	er the mod	ersit e of dying	g, such as	cardiac or	respiratory ar	r Sor rest,	ring, MD 2	Approximate
	Physician	ш	Immediate Cause (Final	nly one cause on	each line.									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		ca <b>r</b> dial o (or as a conse		tion							
	Examiner		Communication line and distance	b										
	D ==	ner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consec	quence ot):								
	certificate be executed nding physician and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	oe execian a	ũ	resulting in death) Last	Due to	o (or as a consec	quence of):								
87	cate t	dical	,	d						_				
9 xo	leath certifica attending pl	/Me	IF FEMALE:	23c If yes o	utcome of pregn	ancy								
Bo	atter for u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	at death 3	Ectopic pr						23d. Date of delined Month	very Day Year
O.	the c y the	ysic	1 □ Yes 2 🛣 No 9 □ Unknown	9□ Unki		Jean J	J Other (Sp	ecily)				-		
٩		y P	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco i	use contribute to	the cause of death?
ecords,	-= W D	d by									101	es 2	□No 3□Pro	bably 4 🖔 Unknown
Ö	> 0 70	Completed									24a. Was	an	24b. Were aut	topsy findings available
$\mathbf{x}$	9 4 9	mo									autop perfo	rmed?	prior to o death?	ompletion of cause of
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical						26 Place	of Death	☐ 1☐ Yes (Check only o	2X No	1 Yes	2 No
<u>&gt;</u>	on (1)	To B	examiner? 1 ☐ Yes 2 <b>X X</b> No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DC	A Othe					6 □Other (Spec	ify)
υof			27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time of Injury		8c. Injury Work	at		3d. Describe t			,
Division	Attending r death. ector: Afler by the fune	Certification:	1X Natural 5 ☐ Pending 2 ☐ Accident investiga	ation	, 22, 7, 32.7	,uty	М		fes 2□N	40				
Ξ	r Att	ij	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Plac	e of Injury - At h	iome, farm, str	eet, factory	, office		28	of. Location (S City or Tox	Street an	nd Number or Rui	ral Route Number,
	ital c			ī						Y				
	Hospital or 24 hours afte Funaral Dir itely filled in I	ical	(Check only 2 Medical E	Physician: To the xeminer: On the	basis of examina	owledge, death ation and/or in	occurred vestigation,	at the tim	e, date and inion, deat	d place, an	nd due to the d d at the time,	cause(s) date and	and manner as	stated. to the cause(s)
	the tha	Medical	one)  29b. Signature and title of certifier	and ma	nner stated.			. License					te signed (Month	
	or with		10.0	I near	4440									
	15		20 Name and address of access	7		m 22c) (T		D 39	793			Sep	tember :	1, 2006
			30. Name and address of person w Christopher J				.,	Phil	in Dr	ive	Olney	MD	20833	
	Sta	ite	31. Date filed (Month, Day, Year)						-F DI	1,	orney	, PIO	20032	
	Registi		SEP 05	2008	Registrar's Sign	7. Jagos	MIL							

8

DHMH 17 Rev 1/2001

State 31. Date Registrar

30 Na

Laron Locke MD.

31. Date filed (Month, Day, Year)

AUG 2 9 2006

10° 19

completed cause of death (Item 23a)

gistrar's Signature

Assistant Medical Examiner

O.C.M.E

111 Penn Street, Baltimore, MD 21201

August 27, 2006

			For State Registrar	State	of Marylan	•	rtment of H		nd Mental Hy	giene Reg. No. 2	006	29716	
	Physici /Medio		1. Decedent's Name (First, Midd Taltha Hill	Acc			1011 23, 200 2. 701 M						
	Examin		4a. Facility Name (If not institution, give street and number)  Doctors Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				4b. City, Town, or Lanham  If Under 1 Year	Location of D		Prince George			
	Funeral Director		579–32–9019 Usual Residence of Decedent 10a. State 10b. County	1□M 2 <b>X</b> F	83	Yrs.	Months Days		Min. (Month, D	ay, Year) -1923		SC  SC  Od. Inside City Limits	
e, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-f show eny injury or other traumatic event, Ite Medical Examinat must be notified at once.	To Be Completed by Funeral Director	DC Washingto							10g. Citizen	1 ☐ Yes 2 🛣 No  10g. Citizen of What Country?		
			Armed Forces?  1 Never Married 2 Married  1 Yes 2 No  1 Yes, Give  Year or Dates:				20018  Was Decedent of Hispanic Origin? (Specify Yes or Ni Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes ② No Specify:  edent's Usual Occupation			No-  14. Race - American Indian, Black, White, etc.  Specify: Black  16b. Kind of Business/Industry			
			(Specify only highest grade completed)  Elementary/Secondary (0·12)  10th  College (1-4or 5+)  House  17. Father's Name (First, Middle, Last)				kind of work done during most of working OO NOT use retired)  keeper  Mary  18. Mother's Name (First, Middle, Maide)			Maryla	yland University		
			Eddie Bouknight  Elnora Bobo  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
			Pearley Hubba  20a. Method of Disposition  1 XBurial 2 Cremation 4 Donation 5 Other (3	3 □Removal from	20b. P	Place of Dispo- semetery, cren	Alcona St sition (Name of natory or other plac In Cemete	:0)	Lanham, M		on - City or Tov		
Baltii			21. Signature of Funerel Service		rshall	22	. Name and Addres	ss of Facility	Marshall's	Funera	al Home	:	
rision of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed TO within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the ettending physicien end ID positive to the Funerel Director: After this certificate has been signed by the ettending physicien and ID positive the funeral director, page 2 should be detached for use as the burial-transit ID	Physician/Medical Examiner	23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shdek, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. AND RAM NUR  Due to (or as a consequence of):							Interval Between			
							Ectopic pregnancy Other (specify)			23d. Date of delivery  Month Day Year			
		Completed by P	Part II. Other significant conditions contributing to death but not resulting in the u				24a. \			Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Onknown  Was an utopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?			
		Certification: To Be Co	25. Was case referred to medicine examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendicines	28c, Injun	28c, Injury at Work?  M 1 Yes 2 No								
			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)				City or T			(Street and Number or Rural Route Number, own, State)			
		Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									the cause(s)	
)	Son Teles	2	29b. Signature and title of certifi	0	29c. License number  Doc 58 275  Print)  STREET SOITE 253			29d. Date signed (Month, Day, Year) 8 - 25 - 0 6					
	4)		30. Name and address of person	who completed can	use of death (Item	1 23a) (Type,	Print)  STREET	5017	e 253	LAUXE	L, MD	20706	
	Sta Regist		31. Date filed (Month, Day, Year SEP 0 6 20	7 106 <b>56</b>	Hegistrar's Signa	Brand	U						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ам 8 2006 9:53 FRANKLIN HILTON 31 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1₫M 2□F 163-34-0566 Yrs. Director 65 PENNSÝLVANIA 3/3/1941 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Items 23s or 28s-f ehow The Madical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo SILVER SPRING MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8715 FIRST AVE. #1522C 20910 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BUILDING ENGINEER COMMUNICATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Pages 1 end 2 should be fit ment of Heelth and Mental H tent: If item 27 le marked ott jury or other treumatic ever ၉ ROBERT HILTON DAISY JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNADETTE HILTON - WIFE 8715 FIRST AVE.#1522C SILVER SPRING, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State ortent: If fort lincoln cemetery 9/3/2006 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MD 22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 21. Signature of Fugeral Service Licensee 3401 BLADENSBURG RD. BRENTWOOD, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY EMBOLISM MIN. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> been sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 202No page 1 ☐ Yes 2 ☐ No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☐XNo 2X ER/Outpatient 3□ DOA 27. Manner of Death 1 Anatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After fojury 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madieat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58597 9/1/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHRYAR DAVARI,. MD 2nd AVE. SUITE 404B SILVER SPRING, MD 20910 8609 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registra SEP 0 6 2006

State of Maryland / Department of Health and Mental Hygiene 2006 State
Registrar Amend#23a.Prt.1.PerPhys.PCC 9-7-06Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:47 AM tenneth 11100 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MARCH 29 1940 9. Birthplace (State or Foreign Country) N . C . 5. Social Security Number 6. Sex **Funeral** 1**⅓**M 2□ F 241 58 9730 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other then "netural", or items 23a or 28a-f ehow traumatic event, the Modical Examinar must be notified at HYATTSVILLE Yes 2 No P.G. MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20912 USA 1325 RAY ROAD by Funeral Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If item 27 is marked other then "netural", or Heme 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) CONTRACTOR JANITORIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BROWN MATTHEW CANARY HOOKS SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1325 RAY RD. HYATTSVILLE, MD. 20912 MATTIE RUTH HOOKS/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot BOONEY TAMILY CEM. 9/9/06 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MAGNOLIA N.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WATSON F. H. 3435 14th ST., N.W. WASH. D.C. 21. Signature Freneral Service License 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MASSIVE ASPIRATION PNEUMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification, funeral director, Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Dir\*ctor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in Ly 4 | Homicide the Hospital or 1. Certifying Physician. To the bast of any knowledge, death codumed at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29a. Certifler Medical (Check only one) 29d, Date signed (Month, Dav. Year) 29b. Signature and the of certifier 29c. License number 45203 09-03-2006 30. If me and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN SMITH M.D. 7600 CARROLL AVE. TAKOMA PARK, MD. 20912 31. Date filed (Month, Day, Year)
SFP 0 7 2006 32. Registrar's Signat<del>ure</del> State Registrar

Phys /Me Exa

Fune Direct

	1	For State Registrar			State o	f Marylar			ent of F ate of				Reg.	ne No. 2 (	106	29719
ician dical	ł	1. Decedent's Nam			R							2. Date of D Month SEPTEN				
niner		4a. Facility Name (						4b. Cit	ty, Town, o					4c. County		
. 4		PRINCE ( 5. Social Security N		HOS 6. Sex	PITAL	7. Age (In yrs.		If Und	CHI der 1 Year	EVERL	Y or 24 Hrs.	9 Date of F	lieth			GEORGES  place (State or Foreign
al or		219 54 5 Usual Residence of	5451		/ 2□F	5		Month		Hours		8. Date of E (Month, I JULY 2	7 <b>,</b>	1951	Col	HINGTON, DC
tor		10a. State	10b. County PRINCE	GEO	RGES		ity, Town or Lo		IGHTS	3						10d. Inside City Limits  XXYes 2 □ No
rec		10e. Street and Nu	mber						Zip Code				10g.	Citizen of	What Cou	untry?
O E		5300 LUI	ввоск к	OAD					20747	7				UNI	TED S	STATES
by Funeral Director		11. Marital Status 1 Never Marr 3 Widowed			. Was Dece Armed Fo IXXYes If Yes, Giv Year or D	2 🗌 No		If Yes, sp	cedent of Hopecify Cuba	lispanic O an, Mexica Specify	an, Puerto	ecify Yes or N Rican, etc.)	No-		ck, White	ican Indian, , etc. ACK
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E O		12TF			0011090 (1	40/3//	STEE	L WO	RKER					PRIV	ATE	
Be (		17. Father's Name	(First, Middle,	Last)						18. Moth	her's Name	e (First, Midd	le, Mai	den Sumai	тө)	
2		ROBERT I		-							ENES I					
		19a. Informant's N JEANETTI				Е			BOCK			TRICT				
			position Cremation 5 Other (Si		noval from	State	Place of Dispo cemetery, cre RYLAND	matory o	r other plac			2/2006		_		Town, State  M. MD
Succe	Ì	21. Signature of Fu	P. M.	Licensee	22			<sup>2</sup> . Mame	shace Shace	se of Fac	ÜNERA	L HOME	OF	' MARY	LAND	,INC.
	1	23a. Part1 Enter t	the disease, or	complica	tions that o	aused the dea	ith. Do not en								2074	Approximate fnterval Between
ical Examiner		Immediate Cause disease or condition resulting in death)  Sequentially list colif any, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)	onditions, nmediate erlying injury s	a. b. c. d.	Hype	or as a consector as	quence of):	war	blee	d						Onset and Death
Completed by Physician/Medic		IF FEMALE: 23b. Was deceden in the past 12 1  Yes 20 9  Unknown	months? □ No	230	1 Live b	come of pregrinth 2 Fet ant at time of own	al death 3[	□Ectopic □ Other (	pregnancy (specify) _	<i>y</i>					ate of delive	very Day Year
d by Ph		Part II. Other signi	ficant condition	ons contr	ibuting to de	eath but not re	sulting in the u	nderlying	g cause giv	en in Part	t I.			co use con		the cause of death?
mplete		Directo,	mely	1 tus								24a. Wa aut per	opsy formed	1?	prior to co death?	opsy findings available ompletion of cause of
ပိ	+	CONGEST 25. Was case refer	7 VE //	PAN	LTF	AILUR	t			ac Plac	an of Dooth	1 Yes		Mo	1 🗆 Yes	2 No
To Be		examiner?		Hos	spital: 111	npatient 2	ER/Outpatie	nt 3 🗆 I	DOA Oth	.05		me 5 Re		e 6 □Oth	ner (Snec	ifu)
atlon: T		27. Manner of Deal 1 Natural 2 Accident	th 5 Pendin investig		28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	ıf M	28c. Injur Wor			28d. Describe				
ertifica		3 ☐ Suicide 4 ☐ Homicide	6 Could r	not be ined	28e. Place buildi	of Injury - At h	nome, farm, st	reet, fact	ory, office			28f. Location City or T	(Stree own, S	t and Numi tate)	ber or Rui	ral Route Number.
Medical Certification:		29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physic Examine	r: On the b	best of my kn asis of examin her stated.	owledge, deat ation and/or in	h occurre vestigation	ed at the till on, in my o	me, date a pinion, de	and place, eath occurr	and due to the	e caus e, date	e(s) and m and place,	anner as and due	stated. to the cause(s)
Me		29b. Signature and	title of certifie					2	29c. Licens	e number			29d.	Date signe	d (Month	, Day, Year)
			1	You	re				D00	434	62		4	7/2/0	06	
		30. Name and add	Λ.	who com	pleted caus	e of death (Ite			HOSP	ITAL	DRIV	E CH	EVE	RLY,	MD	
State strar	_	31. Date filed (Mor		006	82. R	egistrar's Sign	ature	W								

Registrar

			1 - For State Registrar	Amend	It State of Manyla	, 19865°03 Cer	170£767 tificate d	difficaith and of Death	мептаг ну	giene Z U (	16 29720
	Physici /Medic		1. Decedent's Name	(First, Middle, La	Moore His	95			2. Date of De	Day Y	3. Time of Death
E	Examir Funeral Director		4a. Facility Name (If r Souther 5. Social Security Nur 579 - 56 -	nber 6.	ve street and number)  And Huse Sex 1 M 2 F	s. last birthday) Yrs.	011		s. 8. Date of Bir	iy, Year)	Death George Birthplace (State or Foreign Country) ANY ANG
	<u> </u>	tor	Usuel Residence of D	Prince	Geurce 100.0	Clinton	ation			940	10d. Inside City Limits 1
	ath with the 23a or 28a	ral Director	10e. Street and Numb		ndale Dr.		10f. Zip Cod	235_		10g. Citizen of Wha	t Country?
920	72 hours after death with the Maryland "naturel", or fleme 23a or 28a-f ahow citcal Examinational be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4	_	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	/as Decedent of Yes, specify C	of Hispanic Origin? ( uban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No nto Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc.
ιĠ	d within 72 piene. r then "nai	Completed	(Specify		ducation rade completed) College (1-4or 5+)	16a. Deced (Give) life. D	ent's Usual Oci ind of work do. O NOT use ret	cupation ne during most of w ired)	orking	16b. Kind of Busin	
yland	B E D	To Be C	17. Father's Name (Fi			Moore			ame (First, Middle	, Maiden Sumame)	Lihs
	ges 1 and 2 should t of Health and Mer if Item 27 is marks or other traumatic		19a. Informant's Nam 20a. Method of Dispo	Flascue	Son	19b. Mailin	Jenny ition (Name of	Gay Ct	Rural Route Numb	er, City or Town, Sta	21144
	permit. Pages Department of I Importent: If It any injury or o		4 Donation 5	Other (Speci	ity)	36-7 M	Name and Add	dress of Facility	7/06 YA	Branchy	MD 70608
}	Physician /Medical		23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)		nplications that caused the decrease on each line.  a	Joseph	r the mode of o	lying, such as cardia	ac or respiratory a	rfest,	Approximate Interval Between Onset and Death
	ificate be executed XX XX in the purial-transit as the burial-transit and in the burial-transit	Examiner	Sequentially list cond if any, leading to immoduse. Enter Underly Cause (Disease or in that initiated events resulting in death) La-	ring ury	b. Due to (or as a conse	quence of):	TA	lipe			,
. Box	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 1 9 □ Unknown	onths?	dd	al death 3 🗍	Ectopic pregnal Other (specify)			23d. Date of Month	delivery Day Year
rds, P.	signed signed d be de	þ	Part II. Other significa	ant conditions	contributing to death but not re	sulting in the un	derlying cause	given in Part I.			te to the cause of death?  Probably 4 Unknown
tal Reco		e Completed	25. Was case referred	1 to modical	1				12X Yes	osy prior deat 2 No 1	
Division of Vital Records,	ding Phys n. After this funeral di	ToB	examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 2  Accident		28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. In	Other: 4 Nursing	Home 5 Residuel Resid		Specify)
Divis	Dia die	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to	building, etc. (Spec	ify)			City or Tov	vn, State)	r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 (Check only 2 one)  29b. Signature and tit	☐ Medical Exa	hysician: To the best of my kr militer: On the basis of examin and manner stated.	owledge, death auon and/or invi	estigation, in m	time, date and place y opinion, death occ	urred at the time,	cause(s) and manne date and place, and 29d. Date signed (M	due to the cause(s)
	⊢ ≯ <u>⊢</u> 8	1	30. Name and addres	Ato	currented cause of death (Ite	m 23a) (Type P	Do	0415	80	9/5/0	6
A	BID		31. Date filed (Month,	off Re	2150 7503 S	Suratt	71	Clinto	, Mi	25	7.75

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State of Maryland / Department of Health and	Mental Hygien 2	00	)6
Certificate of Death	Reg. No.		

1. Decedent's Name (First, Middle, Last)

Centificate of Death

2. Date of Death

29721

3. Time of Death

**Physician** /Medical **Examiner** 

**Funeral** Director

illed within 72 hours after death with the Maryland item 27 is marked other than "neturel", or items 23s or 28e-f show other traumatic event, if a Madical Examinar, may be mailfied at of Health and Mental Hygiene. item 27 is marked other than 12 should be fi permit. Pages 1 and 2 Department of Health a Important: If item 27 it any injury or other tra <u>once.</u>

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

> use as the burial-transit and attending physician detached for signed by pe 2 should peen certificate has page funeral director, After within 24 hours after death. To the Funerel Director: A the filled in by

The law requires that the death certificate be executed

or Attending Physician:

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Division of Vital Records, P.O. Box 68760,

0220 SEPTEMBER<sup>Da</sup>3, 200<del>0</del> SR. STEPHEN ARTHUR HINES, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WASHINGTON JULIA MANOR HEALTHCARE HAGERSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT . 8, 1 Birthplace (State or Foreign Country)
 WV 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Min. 1 XM 2□ F Yrs 298-14-3923 79 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County HAGERSTOWN 1 Yes 2 No WASHINGTON MARYLAND Director 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 21740 U.S.A. 143 ALEXANDER STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SERVICEMAN TRUCK RENTAL CO. 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEPHENANNA DIXON CLYDE GILBERT HINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 ALEXANDER STREET, HAGERSTOWN, MARYLAND 21740 BEVERLY J. HINES, SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BENEVOLA CEMETERY 9/6/2006 BOONSBORO, MARYLAND 1 4 □ Donation 5 □ Other (Specify) 21. Signature of June al Service Licensee 7606 OLD NATIONAL PIKE 22. Name and Address of Facility BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 Eight the dise us, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelodyspla al mi Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner oronav-Due to (or as a consequence of): e 5 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obstructiva D. SLKIN 1 Yes 2 No 3 Probably 4 Unknown Be Completed Fibrillat. Atwin al 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2**□ N**o 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Matural Injury 5 🗌 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (0 0060396 09/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opa MUNSHED FAR. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 45 M **Physician** 2006 sept Gay Madeline Houser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2X F 73 Sept. 13,1932 Maryland Director 214-32-4887 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or iteme 23e or 28e-f show eny Injury or other traumatic event, the Madical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2√☐ No Funeral Director Williamsport Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 9034 Downsville Pike 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② WNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced White led 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Ella Knadler Andrew Gaylor Daniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald J. Houser, Sr. - Husband 9034 Downsville Pike Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Mem. Park Sept.9,2006 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Os beone me Address e Facility Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter thi disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician me tastatic Carcinoma /Medical Due to (or as a consequence of): Examiner Squamous Carcinoma Cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed otine 11c resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year be detached for 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 3 Probably 4 Unknown 1 ☐XYes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes autopsy performed 1 Yes 2 No 1 Yes 2 No of Vitar or Attending Physicien: completely filled in by the funeral director. 26. Place of Death | Check only one) 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident within 24 hours efter deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Descrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Machain Kubbly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1354 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2006 Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer, **Physician** OHN HARR 1030AM 06 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CENTER MD hester Kiver HESTERTOWN HOSPITA ent If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Funeral 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours 1 XM 2 □ F 86 214-18-9441 Director 08/04/1920 PA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD KENT 1 ☐ Yes 2 🛱 No CHESTERTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itema 23a or 1338 MCGINNES ROAD 21620 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filled within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No WHITE Specify: 3 X Widowed 4 □ Divorced "nstural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) TOOL MAKER MANUFACTURER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN ANNA RYDER P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traum 161 COTTONTAIL ROAD, CHESTERTOWN, MD 21620 JASON HARRIS/SON 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CRUMPTON CEMETERY 09/07/2006 CRUMPTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBE
130 SPEER ROAD, C 21. Signature of Funeral Service Licensee EIN AND NEWNAM FUNERAL HOME, PA CHESTERTOWN, MD 21620 psonxtella 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 ☐ Yes 2 🗹 1 Yes Hospital or Attending Physician: funeral director. medical 25. Was case referred to Be 26. Place of Death | Check only one examiner? Hospital: Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 Tes 2 No hours after death. investigation 2 Accident filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of softifier 29c. License number 6 Name and address of person who completed cause of death (Item 23a) (Type, Print) hanahan 120 Speer RD Blogs Chestertown HD21620 ms 31. Date filed (Month, Day, Year) 32. Registras's Signature State Registrar

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	/Medio		4a. Facility Name (If not institution, give					Location of		August		nty of Death		
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	with the ! a or 28s-	Director	Florida Volusia  10e. Street and Number  4461 Hidden Lake	Drive			t Orai Zip Code 321:			1	0g. Citizen		intry?	
036	be filed within 72 hours after death with the Maryland ital Hygiene.  In the "naturel", or Items 23a or 28s-f ehow event, the Medical Examinating must be notified at	by Funeral		12. Was Decedent Endemed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, s	edent of H	ispanic Ori n, Mexican	gin? (Spe i, Puerto f	city Yes or No- Rican, etc.)		USA Race - Amer Black, White cify:		<b>.</b>
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Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury oc other traumatic ev once.		20a. Method of Disposition 15€ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Place of Dis cemetery, c	rematory c	r other plac	′ [5	o Sept. 2006	9,	20c. Locatio			
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Division of	tending feath. tor: After the fune	Certification: 1	27. Manner of Death  1 X Natural 2 Accident 3 Suicide  2 Could not be	28a. Date of Injury (Month, Day	28b. Time Year) Injur	M			No 2	8d. Describe ho	w injury occ	curred		
<u>&gt;</u>	To the Hospital or At within 24 hours efter of To the Funarel Direct completely filled in by		4 Homicide determined  29a. Certifier txtxcertifying Phys	building, etc.	(Specify)			ne date an		City or Towr	, State)			
	the Hos hin 24 hi the Fun npletely	ledicai		ner: On the basis of e	examination and/or	investigati	on, in my o	pinion, deal	th occurre	ed at the time, di	ate and plac	e, and due	to the cause	(s)
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	Sta		30. Name and address of person who con Alan R. Segal, M. 31. Date filed (Month, Day, Year)		lugo Circ		ilver	: Spri	ing,	MD 2090	6			

			1- State of Maryland / Department Items 23a,25,27,28a-f per electrical per electr	irtment of Health and M MR 6859 09/12/06df	lental Hygien <b>1b</b> Reg. N	2006 29726
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
	Physici /Medic		Robert L.	Hawkins Jr.	February	22,06 8:00A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
4		16	Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Takoma Park  If Under 1 Year   If Under 24 Hrs.	M. Data of Birth	ontgomery
	Funeral Director		220-66-9937   12XM 2   F   50   Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year Septembe:	r) 55 9. Birthplace (State or Foreign Country) r 29, Maryland
	yland iow		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
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Ball	permit. Pages Department of P Important: if ite any injury or of	5 5	21. Signature of Funeral Service Lense 120 AC	Name and Address of Facility Dams Funeral Hor	me, 2060! Aquasco	5 Aquasco Rd.
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>	ys dis	OB	examiner? 1 ★Yes 2★No Hospital: 1 Inpatient 2 ER/Outpatien	Othor	ne 5 Residence	6 ∏Other (Specify)
n of	ding Ph h. After thi funeral	T :uc	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how inju	
ioi	Attending ir death. ector: After by the fune	atlc		MIM 1 □ Yes 2X □ No	s	subject assaulted
Division	- 0	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office 2	18f. Location (Street a City or Town Stat 32.32 Walte	nd Number or Rural Route Numb <b>MD</b> re) <b>Lane, Forestville</b>
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Clieux out) one)  129 Certifying Physicien: To the best of my knowledge, death 2 Inductor Examiner: On the basis of examination and/or invane) and manner stated.	occurred at the time, date and place, a	and due to the cause/s	s) and manner as stated
	vithin o the	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
)	->-0		19	1 174566	٠	2- 2-06
•			30. Name and address of person who completed cause of death (Item 23 11774 e,	Print)		2- 22-06
		53	14300, CALLANT fei	(CN, 12	4 1300	rie wosash
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 2005	Goods!		

## Please Type or Print in Black Indelible Ink

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Deandre Alphonzo	1	For State	St	ate of	f Marylar	nd / De	epartment Certificate	of E	Health ar Death	nd Ment	al Hygi		Reg No	200	16 2972
Physician/		eqistrar . Decedent's Nam	e (First, Middl	e,Last)								Date of Dea	ath		3. Time of Death
Medical Examine		Deandr	e Alı	ohor	nzo I	Lama	r Har	ris	5		s	Month eptemb			0109 hrs
	4	Facility Name (in 501 Topeka	if not institutio			nber)		4b.	City, Town, o		f Death			County of Deatlince George	
Funeral		5. Social Security N		6. Sex	7	. Age (In	yrs last birthday	)	If Under 1 Ye	ar If Unde		Date of B	irth (MM/D	D/YYYY) 9 Bii Forei	thplace (State or
Director		578-13-	8848	1 XM	1 2 F		19		Months Da	ys Hours		Dec.	13,1	C	puntry) Md
A .		Jsual Residence o 10a State				10c	City, Town or Lo	ocation							10d Inside City Limits
i low any	ļ		,	~			•			-h+a					1 XYes 2 No
the Marylanc a or 28a-f sh tifted at onc	-	Md. 10e. Street and Nu	Po	<u> </u>			Capi		Heic 10f. Zip Code	liics		Т	10g. Citize	en of What Cou	ntry?
the Manner and Lifted		1000 H:	iahvie	ew D	rive				207	743			Uni	ted St	ates
Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Itealth and Mental Hyginer and treath 19 show and 18 marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	5	11 Marital Status	,		12. Was Dece Armed For		in U S 13.		Decedent of F , specify Cub				0- 1	4 Race - Amer White, etc.	ican Indian, 8lack,
er deat		Widowed			1 Yes Yes, Give Year	2 <b>X</b>			es 2 <b>X</b> N	In specify			5	Specify. Bla	ale
urs afternaft.		15. Decedent's E		C	r Dates:	complete	ed) 16a Dece	edent's	Usual Occup	ation (Give F				nd of 8usiness	
.0036 within 72 hour giene her than "natt Medical Exar	{	Elementary/Sec	ondary (0-12)		College (1-	4 or 5+)	durin	ng mos	t of working li	fe. DO NOT	use retired)				
5-0036 led within 7 Hygiene other than the Medica		1.2	(E					$Cl\epsilon$	erical	19 Mathar	s Name (Fir	rst Middle	Maidon S	Privat	e
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212 212 Sould be I Ment in mark ic ever	3	19a Informant's Na					19b Ma	ailing A	ddress (Str	eet and Num	ber or Rura	I Route Nu	ımber, City	or Town, State	e, Zip Code)
MD nd 2 sho alth and m 27 is aumati		Thelma		у На	arris	/mot	her U	aga	er Mar	lbor	o $Mc$	1. 20	772	ocation - City or	
or Head		20a Method of Dis 1 XBurial 2		3	Removal fro	m State	20b Place of Dis crematory of	or othe	r place)			ate		,	
Baltimore, oemit Pages I ar Department of Hee Important: If ite injury or other tr	L		Other S				Glenwo								on, DC
Baltimore, MD 21215- permit Pages I and 2 should be filed Department of Health and Membal Hy Important: Hitem 27 is marked of injury or other traumatic event, the	1	21. Signature of Fu		LICOMSO	W 1 1 77	110								wards	ғ.н. I,Md.20746
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/Medical Examiner	1	failure List or Immediate Cause		_	unshot wo	und of	torso								Death
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ivisior I or Attent after death Director:	Cati	2 Accident	5 Per	iding estigation	n		- At home, farm,					f Location	(Street ar	nd Number or R	ural Route Number, City
Division of Vital Records, pital or Attending Physician: The law require ours after death freely far this certificate has been significantly the funeral director, page 2 should be attended to the funeral director, page 2 should be attended.	Certification:	3 Suicide 4 ✔ Homicide		uld not be ermined	е		Family	311001	, ractory, cinc	e banding, e		or Town,	State)		Heights, Md.
hou hou		29a Certifier	Certifying I	hysicia	n: To the bes	t of my kn	owledge, death	occurre	ed at the time	, date and pla	ace, and du	e to the ca	use(s) and	d manner as sta	nrted
To the How within 24 h To the Fin	Medical				On the basis of and manner s	of examina tated	ation and/or inve	stigatio			ccurred at th	ne time, dat			
	2	29b. Signature an	nd title of certif	ier	1	/				ense number C.M.E.				tember 11,	onth, Day. Year)
		30. Name and add	alle	W ?	ompleted caus	e of death	(Item 23a)								
		Zabiullah A			tant Medic			Penr	Street, B	altimore, l	MD 2120	1			
Sta		31. Date filed (Mo			407	egistrar's S	Signature	ort,	2			-			
Registr	ar	SI	EP 18	2006	JE AL	1,46,3	No prof		<del></del>	·					

State of Maryland / Department of Health and Mental Hygiene 006 29729 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Joseph Ireland 2006 10:45 A M Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Upper Marlboro SE Crain Highway 8. Date of Birth (Month, Day, ) May 24, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Mary Land 1 X M 2 □ F Vrs 214-18-8898 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b Count or than "naturel", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 TXYes 2 □ No Director Upper Marlboro Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 149 Crain Highway SE Completed by Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) National Park Service Gardener 12 . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if item 27 ie marked other t jury or other treumatic event, th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mattie Brady ပ Joseph Albert Ireland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Upper Marlboro, MD. 20774 149 SE Crain Hwy. Louise K. Ireland / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State pernit. Page Department of Important: if any injury or once. Metropolitan Crematory 09/06/2006 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 20715 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROSIS S. uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown SICK SINUS SYNDROME 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No CELLULITIS OF LEGS 2 No 1 Yes Division of Vital Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending death. 1 Yes 2 No investigation Director: / 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d To the Funeral Direct 4 Homicide pelli 39s Cartifier 1🗷 Certifying Physicians To the best of my knowledge, death occurred at the time, date and place; and due to the cause(s) and marrier as stated Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/66 10-0018013 Ullram w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Rd. #D203 Joseph P. Caruso, M.D. Clinton, MD. 31. Date filed (Month, Day, Year) . Registrar's Signature State SEP 0 7 2006 Registrar

ران ا		-	FoAmend Item 23a State of Maryland / Department of State of Maryland / Department of Registrar WCHD/SH 9/8/06 per Dr. Certificate of Maryland / Department of Registrar WCHD/SH 9/8/06 per Dr.	f Health and Mo of Death	ental Hygie		29730
. (	~√ Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Mary Beulah Irvin		2. Date of Death Month Sop known		3. Time of Death
	Examin		Washington County Hospital Hage	n, or Location of Death		4c. County of Death Washing	ton
	uneral irector		5. Social Security Number 217-80-9634 6. Sex 1 I M 2 🛣 87 Yrs. Months Da	ys Hours Min.	8. Date of Birth (Month, Day, Ye May 3, 1	9. Birth Cou 919 MD	place (State or Foreign intry)
laryland	ehow ed at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Hagerstown,				10d. Inside City Limits 1 ☐ Yes 2∑No
with the M	a or 28s-f Le notifi	Direct	10e. Street and Number 14014 Marsh Pike 21	740	10g.	. Citizen of What Cou	untry?
G Z IZ IS-UUSO filed within 72 hours after death with the Maryland	of other than "netural", or items 23a or 28s-1 show event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give 1 □ Yes 2 ▼ Year or Dates:	of Hispanic Origin? (Spe Cuban, Mexican, Puerto I No Specify:	ocify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
Within 72 hours af	then "netural re Madical E	Completed I	15 Decedent's Education 16a Decedent's Usual Oc	one during most of workii atired)	ng 16	b. Kind of Business/li residenc	
<b>—</b> 0 -	ked other	To Be Co	17. Father's Name (First, Middle, Last) Harry Miller	18. Mother's Name Bertha	Victor		
Mary nd 2 shou	27 is mar	-	19a. Informant's Name/Relationship (Type, Print)  Carole Goodman daughter  13907 Cou	reet and Number or Rura Intry Side			
Baltimore,	Important: If item 27 is marked any injury or other traumatic ev QDCS.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)		1 .	c. Location - City or 1 Hagersto	
Balti Permit	Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Additional Companies  23. Name and Additional Companies  24. Name and Additional Companies  25. Name and Additional Companies  26. Name and Additional Companies  27. Name and Additional Companies  28. Name and Additional Companies  29. Name and Additional Companies  29. Name and Additional Companies  20. Name and Additional Companies  21. Signature of Funeral Service Licensee	ddress of Facility Edwin Tho 310 Clea	mpson F	uneral H g, MD 21	ome,Inc 722
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), executed	hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
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Box	by the attending phy tached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Nô 9 ☐ Unknown  23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify gold unknown)			23d. Date of deli Month	ivery Day Year
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s Hospite	24 hours • Funeral letely filled	Medicai C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in and manner stated.	he time, date and place, my opinion, death occurs	and due to the cau red at the time, date	se(s) and manner as e and place, and due	s stated. to the cause(s)
To th	within To th comp	Me		0 6 0 3 9	6	Date signed (Month	h, Day, Year)
-Hخ	5		30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  FARID MURSHED)	126 opa	1 et	n mo	21740
<u>₹</u>	St Regist	ate rar	31. Date filed (Month, Day, Year)  SEP 0 7 2006  32. Registrar's Signature  S. Specks				

			State of Maryland / Dep	artment of Health and Mental Hygie	ne2006 29731
			Registrar  1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	. No. 3. Time of Death
П	Physicia	an	-2.500 -00 '-1 street -1	Month	Day Year
	/Medic		NORMA MARY ITNYRE  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	5 2006 4.00 A M
}	Examin	er			
_			WASHINGTON COUNTY HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	HAGERSTOWN  If Under 1 Year If Under 24 Hrs. 8, Date of Birth	WASHINGTON
u	Funeral Director		1□M 21¶ F	Months Days Hours Min. (Month, Day, Ye	
			219-20-4110 81 Trs.  Usual Residence of Decedent	OCT. 21,	1924 maryland
	hours after death with the Maryland lural', or Iteme 23a or 28a-f ehow al Examinar must be notified at		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Mary	ğ	MARYLAND WASHINGTON	HACEDOTOUN	1 ∑ Yes 2 □ No
	the 28s	Director	MARYLAND WASHINGTON  10e. Street and Number	HAGERSTOWN  10f. Zip Code 10g.	. Citizen of What Country?
	With No.		4400 LUTUED DRIVE	24740	11. 6. 4
	leath	Funerai	1183 LUTHER DRIVE  11. Maritat Status 12. Was Decedent Ever in U.S. 13.	21740 Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
	fer o	ᆵ	Armed Forces?  1 Never Married 2 Married 1  Yes 2  No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
ဗ္ဗ	If's a	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: WHITE
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Maryland 21215-0036	Hygid other ent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Mai	
au	uld be dental rked o	To B	EARL REX ITNYRE	MARGARET ELLEN F	DECHED
5	should and Men marke umatic	-		ing Address (Street and Number or Rural Route Number, C	
Ž	end 2 seath ar n 27 io	i	EDWIN R. ITNYRE/BROTHER 20515	PARK HALL ROAD, ROHRERSVIL	LE MARYLAND 21770
ō,	- 로 등 등		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date 20d	LE, MARYLAND 21779 c. Location - City or Town, State
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Baltimore,	permit. Pages Department of I Important: if its eny injury or or			AZI FIINERAI HEIME	National Pike
	46200		Kerry A. Zimmerman	Boonsbord	o, Maryland 21713
			23a. Part 1. Ealth the disease, or complications that caused the death. Do not en shock of heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition Pneumonia		Inveel
	/Medical Examiner		Due to (or as a consequence of):		
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	υ ≕	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	1 1-1	
	nd trans	am	cause (Disease or injury that initiated events c. Congestive	heart failure	Year
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_	5 2 5 0		29a. Certifier Chort cut. (Chort cut. (Cho	th occurred at the time, date and place, and due to the source	ea(s) and manner as stated
	<u>ra</u> 3 <b>je</b> ∃		(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	estigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
	Hospi 24 hou Funer etely fill	음			
	o the Hospi ithin 24 hou o the Funer ompletely fill	Medical	29b. Signature and title of certifier	29c. License number 29d.	Date signed (Month, Day, Year)
`	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	Medic		29c. License number 29d. S	Date signed (Month, Day, Year)
)	To the Hospi within 24 hou To the Funer completely fill	Medic	29b. Signature and Itale of certifier	29c. License number 29d. S	Date signed (Month, Day, Year)  Hitember 5, 2006
\doldon		Medic		29c. License number D44996 SPrint) Lappans R4 Roomse	Sho MD 2171)
ار ارک	4-3+)		29b. Signature and ittle of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Reesstrar's Signature	D44996 S Sill Cappans RA Boonse	Date signed (Month, Day, Year)  Splember S, 200 b  Sho MD 2171)
100 M		te	29b. Signature and fitle of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type,	D44996 S Sill Cappans RA Boonse	Sho MD 2171)

		4	For State Registrar	State of Maryland /	Department of Certificate	of Health and M of Death	lental Hygien	2006	29732
			Decedent's Name (First, Middle, Last,	)			2. Date of Death		3. Time of Death
	Physicia		Lawrence A. Joh	ncon			August 2	9 2006	10:32 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, To	wn, or Location of Death		c. County of Death	
	LAGITITI	٠.	Casev House/M	lontgomery Hospi	ce	Rockville	e	Montg	gomery
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last	birthday) If Under 1 '	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign intry)
-	Director		577-48-9968 <sup>1X</sup>	DM 2□F 70	Yrs.	7,00.0			sh., DC
	2 ,	-	Usual Residence of Decedent  10a. State 10b. County	10c City T	own or Location				10d. Inside City Limits
	anyla ehov	2	Maryland Prince G		0771 07 2004(1011	Capitol He	iohts		1 XYes 2 No
	Ba-1	Director	10e. Street and Number	eorge 3	10f. Zip Co			Citizen of What Cou	intry?
	with a or	급			151. 2.5 5	20743		United S	
	eath	era	1229 Capito1 H	12. Was Decedent Ever in U.S.	13. Was Deceden	nt of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian,
	ter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 27 No	If Yes, specify	Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
9	urs a	Þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 🏋	No Specify:		Specify: ]	Black
Ď	within 72 hours after death with the Maryland ene. Then "naturel", or items 23a or 28a-f ehow ha Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		6a. Decedent's Usual (	Occupation done during most of work	ina 16b.	Kind of Business/li	ndustry
2	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use				
2	ed wi	Sol	12th		Ma	intenance	e (First, Middle, Maid	Priva	ıte
פ	d oth	Be	17. Father's Name (First, Middle, Last)			18. Mothers Nam	•	,	
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Meantal Hygiene and Meantal Hygiene is marked other then "naturel, or items 23a or 28a-1 show aumatic event, the Madical Examinar must be notified at	ဥ	Leroy J		10. 14. 11. 4.4	Street and Number or Rur	Martha		in Codol
Maryland 21215-0036	12 sh hand 7 ie m raum		19a. Informant's Name/Relationship (7) Viola M. Johns			necticut Av			
	1 and 16alth 5m 27 ther t		20a. Method of Disposition	20b. Place	e of Disposition (Name	of		Location - City or 1	
altimore,	Pages nent of I int: if it		1 Burial 2 □ Cremation 3 □	Removal from State	etery, crematory or other	er place)	/2006	Cud+1 and	MD
Ë	it. Partiment		4 □ Donation 5 □ Other (Specify, 21. Signative of Funeral Service License	A -		al Cem \$ 9/6. Address of Facility	Stewart Fu	Suitland,	
Ba	permit. Pages 1 and 2 should be Department of Headth and Menta Important: If item 27 is marked any injury or other traumatic e <u>pnce</u> .	Į, į	Signature of individual Solving Elsonic	Fam t TI		1 Benning R			
			23a. Party Enter the disease, or comp shock, or heart failure. List only of	olications that caused the death.					Approximate Interval Between
٥	Dhaminina		Immediate Cause (Final	End Stage Sp					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequen		Tial degene	lacion		
П	Examiner								
		je.	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ice of).				
	cuted nd ransit	Examiner	that initiated events	С,					
oʻ	en ar		resulting in death) Last	Due to (or as a consequen	ice of):				
8760,	The law requires thet the death certificate be executed ste has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dlcal		d					
9	seath certific ettending pl	Med	IF FEMALE:					f	
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3 Ectopic preg			23d. Date of deli Month	very Day Year
o o	the e	Sc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown	h 5 ☐ Other (spec	сту)			
<u>о</u> .	thet the de led by the detached	by Physician/Me	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying cau	use given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ds,	signed be		•	•			1 ☐ Yes	2 □ No 3 □ Pro	obably 4 🛣 nknown
Ö	w requir been si should	Completed					24a. Was an	24b. Were au	topsy findings available
Rec	has ge 2	E D					autopsy performed	prior to death?	completion of cause of
a	n: Ti ficete or, pa	e Co	25. Was case referred to medical			26 Place of Dea	1 ☐ Yes 2 [X] th (Check only one)	[No 1∐Yes	2 <b>X</b> No
₹	Physician: r this certifice ral director, p	To Be	examiner? 1  Yes 2  VNo	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient 3□ DOA	0.1	ome 5 Residence	e 6 🕅 Other (Spec	(v) Hospice
ō	9 Phy er this eral o		27. Manner of Death	28a. Date of Injury 28	3b. Time of 28	c. Injury at Work?	28d. Describe how in		" Hobbice
<u>o</u>	Attending it death.	atlo	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	Atte ecto by th	1	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory,	office	28f. Location (Street City or Town, St		ıral Route Number,
ō	s afte el Dir ed in	Certification:		Squarily, stor (speedy),					
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical		ysician: To the best of my knowled					
	To the H within 24 To the F complete	ledi	one)	and manner stated.					
	To To COL	Σ	29b. Signature and title of certifier	20.00.		License number		Date signed (Monti	•
^				1 Million	B, DU A	005803; Cynthia M.	Z (U	De const	0,2006
L	(6)		30. Name and address of person who Montgomery Hosp:		3a) (Type, Print)	cynthia M.	williams, 1e. Mn 20	<i>0</i> .0.	
	C)	ate	31. Date filed (Month, Day, Year)			u., ROCKVII			
	Regist		SEP 0 5 2006	2. Registrar's Signatur	Grade				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 27 2006 1900 August Gerald V. Jackson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1XM 2□ F Mar. 23, 1918 88 Massachusetts Director 014-01-6385 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show treumetic event, the Madical Examiner must be notified at 1X Yes 2 □ No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20008 United States Iteme 23a 4545 Connecticut Ave., NW Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☑ No Specity: Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Government Administrative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil ment of Health and Mental H tant: if item 27 is marked ott jury or other treumatic even Henry Jackson Esther Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1732 Q St., NW Wash., DC 20009 Myrna L. Fawcett/Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 9/15/2006 Lee's Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Nome 21. Signature of Funeral Service Licen ee Wash., DC 20019 4001 Benning Rd., NE house 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cuse (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 D No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hoepital or At within 24 hours after d filled in by 4 | Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054579 Barel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18/of- Prince Phillip Drive dney MD 20832 MAHETEME BAYEH M.D. 31. Date filed (Month, Day, Ye ) State SEP 0 5 2006 Registrar

Physicia	an -	For Amend Item 25 Registrar  1. Decedent's Name (First, Middle, Last) ELIZABET					2. Date of Death Month June 12	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s Harford Memorial	treet and number) Hospital			r Location of Death le Grace		4c. County of De Harford	
Funeral Director		5. Social Security Number 6. Sex 215–44–1425	7. Age (In y	rs. last birthday Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1/1/194	9. B 6 Ma	irthplace (State or Foreign Country) ryland
within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28a-f ehow he Modical Examinar must be notified at	2	Usual Residence of Decedent  10a. State 10b. County  MD Harford		City, Town or l					10d. Inside City Limits 1XXes 2 □ No
a or 28a-f	Directo	10e. Street and Number 1528 Deerfie			10f. Zip Code 21034		10	ig. Citizen of What C USA	Country?
Department of Health and Mental Hygiene, Institutal, or itams 23a or 28a-f ehow Important: If Item 27 is marked other than "natural, or itams 23a or 28a-f ehow any injury or other treumatic event, the Modical Examinat must be notified at ones.	Completed by Funeral Director	11. Marital Status  17 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes ♣️∰No If Yes, Give Year or Dates:	1 U.S. 13	Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify hi	nite, etc.
than "natur se Medical	mpleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire VISOY	pation during most of work d)	ang	6b. Kind of Busines	ŕ
ked other ic event, ii	To Be Co	17. Father's Name (First, Middle, Last)  Kyle W. Jones		1 1		18. Mother's Nam Lucille	e (First, Middle, M		
27 is mar er treumat		19a. Informant's Name/Relationship (Ty Nancy J. Lytle- sis						City or Town, State, City, OK	
ant: if item ury or othe		20a. Method of Disposition 1 ABSurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Ha	b. Place of Disp cemetery, cri LIOIO M	position (Name of ematory or other plane) Garde	ms 6/15/		Oc. Location - City of 1dino, MD	
Importa any inju		21. Signature of Funeral Service Licens	tordels	Ha		.Inc.,600		., Delta,	PA 17314
ysician Medical		23a Part : Error the disease, or complishock of heart failure. List only or to hediate Cause (Final disease or condition resulting in death)	tations that caused in decause on each line.  Due to for as a con-			ng, such as cardiac	or respiratory arre	St,	Approximate Interval Between Onset and Death Few DAYS
miner	ner	Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	11'	EMIA			1		Few Days
physicien and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Dur to (or as a con-	Sequence of): 0515	N	- U	A BY MEDIC	AL EXAMINER	Few Days
been signed by the attending phe should be deteched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	CESTIFICATION		23d. Date of d Month	lelivery Day Year
y signed by	þ	Part II. Other significant conditions con	ntributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Did tob		to the cause of death?  Probably 4 Unknown
ite hes bee oage 2 shou	Completed						24a. Was an autopsy penform 1 Yes 2	prior to death'	
r this certifica ral director, I	Be	25. Was case referred to medical examiner?	fospital: 1 Anpatient :	2 □ ER/Outpati	ent 3□ DOA Ot	200	th Check only one	nce 6 Other (Sp	again)
ours after death.  Neral Director: After this certificate hes filled in by the funeral director, page 2.	ation; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		of 28c. Inju	4   Nulsing n	28d. Describe ho		эвспу)
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, secify)	street, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
24 hour	Medical		sician: To the best of my ner: On the basis of exan and manner stated.						
within To th comp	W	29b. Signature and title of certifier	0-1/	1 / 1		se number	29	Od. Date signed (Mo	MD . 21060
	1	1/and	va / Kral	V /	PUS	$OO \cap O$		16/13/	00

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician 2137 September Robert Soahr Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1/18/1936 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6. Sex **Funeral** Months Days Hours Min 1**X** M 2□ F 227-44-0484 Yrs. 70 Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Harford 1 √Yes 2 No Aberdeen Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1238 601 Cornell Street Apt. 110 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
12 Yes 2 No
14 Yes, Give
Year or Dates: 1959-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Specify White þ 3X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) e filed within 7 ai Hygiene. f other than "n Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction nd 2 should be filed valid end Mental Hygie 27 is marked other in traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Edward Johnson Ruby Isabelle Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health end Important: if item 27 is m any injury or other traum once. Sheree Jones (Daughter) 3707 Aldino Rd., Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Harford Memorial Gardens 9/14/06 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 may Part 1. Enter the disease, and including that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, including the ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Shock Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 14 The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by arterz 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic obstructive pulmonary disease 1□ Yes 2₽No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 16 ၀ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred H spitsi or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation **Director**: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Fineral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica PC Certifying Physician: To the best of my knowledge, death occurred at the time, deat and place, and death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier H55222 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aul Little 50 5. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 1 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** September 1, 2006 Randolph King, Sr. Maurice 1:10 A. M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard 5340 Thunder Hill Road Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1927 9. Birthplace (State or Foreign Country) Guyana 5. Social Security Number 6 Sex **Funeral** Days 1**7** M 2□F Months 78 Yrs. 218-02-1060 November 3, Georgetown, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Columbia Maryland Howard Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 United States 21045 5340 Thunder Hill Road Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Guyana Minister of at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Agriculture Permanent Secretary years 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked of Ena Hyacinth Gaskin Ingram Rudolph King 19a. Informant's Name/Relationship (Type, Print)
June Bishop King (Wife) &
Zoey King Jonas (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5340 Thunder Hill Road; Columbia, Maryland 21045 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Sept.6,2006 1 X Burial 2 Cremation 3 Removal from State 5 Department of Important: If any injury or once. Gate of Heaven Cemetery Silver Spring, Maryland '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Server Licenses Name and Address of Facility
No. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Admocarcinena & Lung-mitastatic to bent Immediate Cause (Final 14 months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes LAPERW 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Funaral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. 29a. Certifier Medical the To the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5, 2006 030573 September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John K. Minford, M.D.; 11065 Little Patuxent Parkway; Columbia, Maryland 21044 2. Registrar's Signature-31. Date filed (Month, Day, Year) SEP 0 6 2006 Registrar

		-	For State Registrar	State of Man	yland / Dep <i>Ce</i>	artmer <i>rtificat</i>	t of He	ealth a Death	nd Me	ental H	ygien Reg. N	<sup>e</sup> 20	06	297	137
	ysicia Aedic		1. Decedent's Name (First, Middle, La Virginia Mari	•						2. Date of D Month Sept.	D	åy 2006	Year	3. Time of D 1:00A	Death M
	amin	er	4a. Facility Name (If not institution, giv Southern Maryland	Hospital C		Clir	nton	Location of	Death		P:	c.County			
Fun Dire			5. Social Security Number 6. S 578–28–5163  Usual Residence of Decedent	ex 7. Age (/ □ M 2X F 82	n yrs. last birthday) Yrs.	If Under Months		Il Under 2 Hours	Min,	8. Date of E (Month, L Jan •	lirth Day Yea 17,	1924	LOU	place (State or I Intry) Sachuset	
e Maryland	tified at		10a. State 10b. County Prince G		oc. City, Town or Lo Camp Spri									10d. Inside City 1 ☐ Yes 2	
th with th	ast be no	ai Director	10e. Street and Number 6206 Joyce Drive			10f. Zip	)748				10g. C	itizen of V US		ntry?	
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at the Health and Mental Hygiene. If Item 27 Is marked other then "natural", or Items 23a or 28a-f show	Examinarin	by Funeral	11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece II Yes, spe 1  Yes	cify Cuban	panic Orig , Mexican, Specify:	in? (Spec Puerto R	cify Yes or Nican, etc.)	lo-	Blac	e - Ameri k, White,		
21215-0 3 within 72 ho 3 jene. r then "natur	the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2 th	ducation ide completed)  College (1-4or 5+)	16a. Dece (Give life. House	kind of wo DO NOT u	al Occupat ink done du se retired)	tion uring most	of working	g		Kind of Bu	isiness/Ir	ndustry	
aryland should be filed and Mental Hyge	ic event,	To Be C	17. Father's Name <i>(First, Middle, Last,</i> Hoke Hunt Lee							(First, Middlerson	le, Maide	n Sumam	e)		
Maryla nd 2 should th and Men 27 le marke	r traumat	-	19a. Informant's Name/Relationship (Philip Karp/Husba							Route Num				o Code)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 1s marked other than "natural", or	any injury or other once.		20a. Method of Disposition  1. Surial 2 Cremation 3  4 Donation 5 Other (Specification 21. Signature Funeral Service Licer	Removal from State		Vetei Name ar	cans ad Address	Cem. o	Geo.		alas	Chelt Fune	enha eral		/lan
Physic /Med Exami	ical ner	Examiner	23a Part 1. Enter the disease, or comshock, or heart laiture. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	one cause of each line.	PIRA TIU			, such as c			arrest,			Approximate Interval Betwee Onset and De	ath
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed in death. ector: After this certificate has been signed by the attending physicien and	the bu	Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Due to (or as a co	oregnancy Fetal death 3	⊒Ectopic pi ] Other (sp						23d. Date Mor		ery Day Ye	ar
cords, P.O. Box w requires that the death cer	ould be detac	ed by Ph	Part II. Other significant conditions o		ot resulting in the u	nderlying c	ause giver	in Part I.			tobacco			he cause of dea	
Division of Vital Records, a or Attanding Physician: The law requires that desired that.  Director: After this certificate has been signer.	, page 2 sh			TRAIT	1N F 18	(TIV)	~				s an opsy formed? 2KQN	P	rior to co leath?	ppsy lindings av impletion of cau 2 No	railable ise ol
Vita sician certif	recto	20	25. Was case referred to medical examiner?	Hospital:	a C 5000		Othor			Check only					
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	e funeral d	ation: To	1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatier 28b. Time o Injury		8c. Injury a Work?	4 🗀 14013	28	e 5 🗆 Res 8d. Describe				(y)	
Divis	led in by th	Certification:	3 Suicide 6 Could not be determined	building, etc. (S	Specify)					City or To	own, Stai	re)		al Route Numbe	er,
To the Hospital within 24 hours a To the Funeral I	ipletely fil	edical	one)	ysician: To the best of m niner: On the basis of ex- and manner stated	amination and/or in	vestigation	, in my opii	nion, death	place, an	nd due to the d at the time	e cause(s , date an	s) and mai id place, a	nner as s and due to	tated. o the cause(s)	
To With	000	Σ	29b. Signature and title of certifier		7		:. License i					ate signed		Day, Year)	
23			30. Name and address of person who Gurbux Nachnani,			Print)			n,MD	. 2073	35				
Re	Stat gistra	_	31. Date liled (Month, Day, Year) SEP 0 6 2008	2. Registrar's	Signature	D									

			1 - For State Registrar	State	of Maryland	Departm Certific	ent of Hea	alth and Me eath		iene20	06	29738
6		es.	Decedent's Name (First, Midd	le, Last)					2. Date of Deat	h	M. T. I	3. Time of Death
	Physici /Medio		Lee H. Kie	er					Month August	29	Year 2006	9:20 A M
A. S.	Examir		4a. Facility Name (If not institutio	n, give street and n	umber)	4b. (	City, Town, or Lo			4c. Count		
		*	Larkin Chase					Bowie		Pri		eorge's
	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs. last	Yrs. If U		Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,			lace (State or Foreign try)
*	Director		225-10-7826 Usuaf Residence of Decedent		93	110.		S	ep. 13,	1912	Vi	rginia
	yland		10a. State 10b. County	,	10c. City, T	own or Location					11	Od. Inside City Limits
	a-f st	혅	Maryland Princ	ce George	' s		Uppe	r Marlbo	ro			1 XYes 2 No
	or 28	Director	10e. Street and Number			101	. Zip Code			Og. Citizen of	What Coun	try?
	23a		13201 Cap					20774			ed St	
	ter deel	Funeral	11. Marital Status	Armed F		13. Was D If Yes,	ecedent of Hispa specify Cuban, N	anic Origin? (Spec Mexican, Puerto R	rfy Yes or No- ican, etc.)		ce - Americ ck, White, (	
36	rs a	by F	1 ☐ Never Married 2 ☐ Mar 317 Widowed 4 ☐ Divorced	rned 1X1Yes If Yes, G Year or	2 No Bive	1 🗆 Ye	es 2X No S	Specify:		Specif	y: B:	lack
21215-0036	72 hours "natural",	ed	15. Deceder	nt's Education	1	6a. Decedent's	Usual Occupation	n		16b. Kind of B	lusiness/Inc	dustry
215	hin 72	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	(Give kind o	if work done durir OT use retired)	ng most of working	9			,
21	od wit	Completed	12th		(1.10.01)		Barbe	r		Sel:	f-Emp	Loyed
p	al Hy d oth	Be (	17. Father's Name (First, Middle,	Last)			18.	. Mother's Name	(First, Middle, N	Maiden Surnar	ne)	•
yla	Ment Ment arke	မ		es Kier						a Irvi		
Maryland	s 1 and 2 should be filed within 72 hou Health and Mental Hygene. Item 27 is marked other than "natural other traumatic event, II a Madical E.		19a. Informant's Name/Relation:  Joseph S. Ki			-		Number or Rural		-		
	1 an 1eat 1eat 1m 2		20a. Method of Disposition		20b Place	e of Disposition		ell Ct.,		Maribo:		
Baltimore,	permit. Pages Department of I Important: If its eny injury or of		1 □ Burial 2 □ Cremation		n State cemi	etery, crematory	or other place)	1				
를	artme artme ortant Injury		4 ☐ Donation 5 ☐ Other (S		ROILI		n Cemete	ery 9/5/	2006 tewart :	Philad		
Ba	Department of the partment of		100	V Das	my TII			enning R				
	F		23a. Part1. Enter the disease, o	r complications that	caused the death. [	Do not enter the					, 50 .	Approximate
	Physician		shock, or heart faifure. Lis	t only one cause on								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to	Cardiac o (or as a consequen		ia					
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	P =	ner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequen	ce of):						
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	cate be executed obysician and the burial-transit	ũ	resulting in death) Last	Due to	o (or as a consequen	ce of):						
8760,	cate t	dical		d								
9 X	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Physiclan/Me	IF FEMALE:	23c. ff ves. o	utcome of pregnancy	,				224 D-	4 6 - d - E	
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetal de	ath 3 □Ectop	r (specify)			1	ite of delive onth	ry Day Year
o.	t the de by the stached	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk			. (920)/					
Д,	s that ned t	by PI	Part If. Other significant conditi			ng in the underlyi	ng cause given ir	n Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
rds	w requires been sign should be	ed b	F	ailure to	thrive				1 ☐ Ye	s 2 🗆 No	3 🗌 Proba	ably 4 🔀 Unknown
Vital Records,	aw re s bee 2 sho	Completed							24a. Was ar	24b.	Were autop	sy findings available
Ä	The lav sete has page 2	E O							autopsy perform 1 Tes 2	ied?	prior to con death? 1 \(\sum \) Yes	npletion of cause of
ita	sician: T certificet rector, pa	Be C	25. Was case referred to medica examiner?	al la			26	. Place of Death				
of V	Physician: this certific ral director,	Tol	1 ☐ Yes 2 🔀 No			Outpatient 3	DOA Other:	4  ▼ Nursing Hom	e 5 🗆 Reside	nce 6 🗆 Oth	ner (Specify	)
U	ding P h. After t funera	on:	27. Manner of Death 1 X Natural 5 □ Pendi	ng 28a. Date (Mo	of Injury 28 nth, Day Year)	b. Time of In <sub>f</sub> ury	28c. Injury at Work?		3d. Describe ho	w infury occur	red	
Sio	Attending r death. ector: After by the funer	cat	2 Accident invest	not be		М		2 □No				
Division	i Dirt	Certification:	4 Homicide	nined   200. Flat	ce of fniury - At home ding, etc. (Specify)	, tarm, street, fa	ctory, office	28	City or Town		oer or Rural	Route Number,
	Hospital or 24 hours afte Funeral Dit tely filled in		29a. Certifier 17 Certifyi.	na Physician: To th	ne best of my knowle	dge death occu	rrad at the time.	date and place, ar	nd due to the co	uco(c) and m	20001 20 01	ntad
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only 20 Medical one)	Examiner: On the	basis of examination nner stated.	and/or investiga	ation, in my opinio	on, death occurred	at the time, da	te and place,	and due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie	7 e			29c. License nu	ımber	29	d. Date signe	d (Month, L	Day, Year)
			<b>)</b>	F			D570	28		Sept	ember	1, 2006
0	(8)		30. Name and addless of person	who completed cau	use of death (Item 23	la) (Type, Print)						
	0			ya Chopra	, M.D. 6	00 Ridge	ely Ave.	, Ste. 2	31 Ann	apolis	, MD	21401
13885	Sta Registi		31. Date filed (Month, Day, Year	32.	Registrar's Signature	late:						
	riegisti	aı	SEP 0 5 20	JUD JUD	THE ME							

State of Maryland / Department of Health and Mental Hygiene 2006 29739 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** september 4 2006 Elma Mae Kretzer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min. Yrs. Director 90 July 5, 1916 214-09-1643 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f ehow traumatic event, the Medical Execution must be notified at 1 Pes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 327 South Locust Street 21740 Itame 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 ŏ Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental P Elmer French Mary Sprecher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 l 327 South Locust St Hagerstown MD 21740 Harry Wagaman Kretzer / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its eny injury or of snce. 1 urial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) 9/9/2006 Cedar Lawn Cemetery Hagerstown Maryland 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 DAYS MYOLFRDIAL INFANCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PARENIOSCUSAOTIC YEARS Sequentially list conditions, if any leading to initialist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MEHAT DISENSE Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death P.O. 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 2 1485 TES MELLITUS, TOPE II 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificete 2 No 1 Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident Director; / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7000 1040 09-05-2006 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00H-2 19128 339 HAGERS TOWN MI) E. ANTHETRM BARAY COKEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 08 2006 Registrar

			1 - For State Registrar	State of Ma	aryland	/ Depa	artment of h tificate of	lealth and Death	Mental H	ygiene / Reg. No.	2006	29740
	Physici /Medic		Decedent's Name (First, Middle, La     JAMES HENR	Y KEMP,	SR.				2. Date of D Month SEPTEI		8 2 <sup>°</sup> 0°06	3. Time of Death 12:05a M
	Examir		4a. Facility Name (If not institution, given Chester River	Hospita:				ertown		K	county of Death	
	Funeral Director			Sex 7.Ag	71	st birthday) Yrs.	If Under 1 Year Months Days		in. Jan	23 19	9. Births Coul Mar	place (State or Foreign ntry) Yland
	a-f show	ctor	10a. State 10b. County MD Kent			Town or Lo	cation rtown					10d. Inside City Limits 1 ☐ Yes 2 1 No
	23a or 28	ai Director	10e. Street and Number 24039 Chestert	own Rd.			10f. Zip Code 2162	0		-	en of What Cou S • A •	ntry?
0-00-0	urs atter des al', or Items Executation	by Funeral	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		ĺ	Was Decedent of Information of Yes, specify Cub	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or f erto Rican, etc.)		4. Race - Americ Black, White, Specify: V	
0-01717	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any follow or other traumatic event, the Medical Exacilizational Securities and once.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retire .mber	during most of v	working	Kent		dustry ty Water artment
/land	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last Henry Kemp	')					<sub>lame (First, Midd</sub> (ae Wal		Gurname)	
, Mar	and 2 sho ealth and h m 27 is ma		19a. Informant's Name/Relationship		on)	P.O.	Box 45		vest,	AL. 3	35749	
pairimore	Pages 1 tment of H tant: if iter		20a. Method of Disposition  12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of	fy)	cen	ester ester	sition (Name of natory or other pla Cemete	ery 9/1		Ches		wn, MD.
o O	permit Depar impor any in		21. Signature of Furgeral Service Line	M	00510	) 11	8 West	Cross	St. Ga	lena,	ephen I	Schaech 21635
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heaft failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  b Due to (or as  c	a conseque	nce of):	Laudio Vi	43				Interval Between Onset and Death 4 perus
. DOX OO LOO,	death certificate be executed e attending physician and Id for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant at	of pregnance	cy eath 3	Ectopic pregnance	,		23	3d. Date of delive	ery Day Year
us, r.o	luires that the r signed by th ild be detache	þ	9 □ Unknown  Part II. Other significant conditions  Motastatic Lu							I tobacco use		he cause of death?
II Records,	: The law rec cate has bee page 2 shou	Completed	Motastatic Lu Cervical Disc D	z:Spina	Stei	10015	5.^		24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
NI OI VIIAI	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	To Be	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie	ry 2	R/Outpatien 8b. Time of Injury	28c. Injur	er: 4 □ Nursing y at k?	Death (Check only Home 5 Re 28d. Describ	sidence 6		y)
DIVISION	el or Attences after death	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	OB Disease ( lai	ury - At hom c. (Specify)	ie, farm, str	M 1 ☐ eet, factory, office	Yes 2 □No		(Street and lown, State)	Number or Aura	al Route Number,
	the Hospit in 24 hours the Funers poletely tille	edical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examinatio	edge, death n and/or inv	estigation, in my o	pinion, death or	ice, and due to the courred at the time	e, date and p	place, and due to	o the cause(s)
1	5)	×	29b. Signature and title of sertifier		1ab- 44-			e number	2	29d. Date	signed (Month,	Day, Year)
7	ns Sta		30. Name and address of person who Neil Stoddard  31. Date filed (Month, Day, Year)	l, M.D.		3rown		nester	cown, M	D. 21	1620	
ą.	Registr		· · · · · · · · · · · · · · · · · · ·	8 2006 ▶ 🔏		A	A work					

			1 - For State Registrer	State of M	1arylar	nd / Depa <i>Cel</i>	artmen rtificat	t of H e of L	ealth a Death	and M	lental H	ygiene Reg. No.	20	06	29	374
			1. Decedent's Name (First, Middle, Las	")							2. Date of D	eath		·	3. Time o	of Death
	Physic /Medi		Jorgen Borch Koll	e							Month Septem	ber 1		′өаr 06	8:55	РМ
	Exami		4a. Facility Name (If not institution, give	street and number	r)		4b. City,	Town, or	Location of	of Death		4c.	County of	Death		
			Suburban Hospita					nesda					ntgor			
	Funeral Director		007-20-0214	X 7. A	ige (In yrs. 83	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, L Apr. 2	irth Day, Year) 24, 19	923	Birthpl Count Denn	ace (State try) nark	or Foreign
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	Od. Inside (	City Limits
	Mary -1 sh	to	MD Montgomer	У	Ве	thesda									1 🔯 Yes	s 2 No
	h the	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wh	at Coun	try?	
	23.0 (d)		5528 Devon Road				20	814				Unite	d St	ates	3	
	be lied within 72 hours after death with the Maryland Hygione. Id other then "natural", or items 23e or 28e-f show of other then "natural", or items 20e or 28e-f show event, the Medical Examinar must be notified at	by Funeral	11, Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	i? <b>∑</b> No		Was Deced If Yes, spec 1 \(\sum \) Yes	cify Cuba	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)		14. Race - Black, Specify:	White, e	etc.	
	2 hou	led	15. Decedent's Ed	ucation		16a. Dece	dent's Usua	al Occupa	ation			16b. Kir	nd of Busi	ness/Ind	ustry	
	Media 7	Completed	(Specify only highest grad	le completed) College (1-4o	r 5+)	(Give	kind of wo DO NOT u	rk done d se retired	furing most )	t of worki	ng				,	
ı	or the	Son	Elementary/Secondary (0-12)			Busin	ess E	xecu	tive			Trav	rel A	genc	У	
,	2 should be filed volunt and Mental Hygie Is marked other treumatic event, In	Be	17. Father's Name (First, Middle, Last) Otto B. Kolle								(First, Middl					
	ould Men narke	မ									strup-					
	12 st h and 7 Is n treun		19a. Informant's Name/Relationship (7)								/ Route Num		Town, St	ate, Zip	Code)	
î	1 and Healt Healt Healt	1	Diana Dahan / Wif	е	20b.	Place of Dispo	sition (Nar	ne of			MD 20	_	cation - Ci	ty or Toy	wn. State	
	age and of age		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify			cemetery, crer tional					6 06		s Ch			
	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked eny injury or other treumatic edono.		21. Signature of Fuperal Service Licens						. ,	y Jos	6,06 eph Ga					
	Depermine on y la conce	1	halithany K.	Buck		5	130 W	isco	nsin	Ave.	WW Wa	shing	ton 1	DC 2	0016	
			23a. Part1. Enter the disase, or comp shock, or heart failure. List only of	lications that cause	ed the dea	th. Do not ent	er the <i>m</i> od	le of dying	g, such as	cardiac o	r respiratory	arrest,			Approxima Interval Be	ite
6	hysician		Immediate Cause (Final disease or condition											Ι	Onset and Hou	Death
	/Medical		resulting in death)	a. <u>ACUTE</u> Due to (or a		ardial	TIII	ITCLI	.011					12	. nou	LS
	Examiner		Sequentially list conditions	b												
	p i	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consec	quance of).										
	centificate be executed of only physicien and use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consec	quence of):								t		
	cate b	dical	W.	d.						_						
	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcom 1 Live birth 4 Pregnant	2 ☐ Feta	al death 3	Ectopic pr					2	3d. Date o		,	Year
	at the by th tache	hys	9 Unknown	9□ Unknown												
	w requires that the de been signed by the a should be detached to	þ	Part II. Other significant conditions con Thoracic Aortic A		but not res	sulting in the u	nderlying c	ause give	n in Part I.			tobacco us	_	ute to the		death?  Unknown
	as be	ompieted	Abdominal Aortic	Aneurism	ì						24a. Wa		24b. We	re autop	sy findings	available
	The law ste has page 2 s	E									auto peri 1 1 Yes	ormed?	dea	th?	pletion of o 25⊘ No	cause or
	ysicien: The list certificete hadirector, page	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	-			X	
	Physicien: rthis certific ral director.	2	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpa		ER/Outpatien			4 🗀 190	rsing Hon	ne 5□Res	idence 6	Other	(Specify)		
	th. : After t funera	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury	M 2	8c. Injury Work 1 ☐ Y	at ? /es 2 □ f		28d. Describe	how injury	occurred			
	To the Hospitel or Attending Pn within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of li building, e	njury - At h	ome, farm, str fy)	eet, factory	/, office		2	28f. Location City or To	(Street and own, State)	Number	or Rural	Route Nun	nber,
	the Hospitel of this 24 hours of the Funeral D mpletely filled in	edical (	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	sician: To the besiner: On the basis and manners	of examina	owledge, death ation and/or in	occurred estigation	at the tim , in my op	e, date and pinion, deat	d place, a	and due to the ed at the time	cause(s) , date and	and mann place, and	er as sta due to	ted. the cause(	s)
i	To the within 2 To the Complet	ž	29b. Signature and tale of certifier	11			290	. License	number			29d. Date	signed (/	Month, D	lay, Year)	
	rif	1	/ Jarel	ulkl	15		I	01381	18 - 1	MD		Sept	. 2,	200	5	
	- /		30. Name and address of person who c						-			00015				
			Gary P. Fisher M				. #73	30 Cł	nevy	Chase	e, MD	20815		-		
	Sta Regist	ate	31. Date filed (Month, Day, Year) SFP 0.5 20	32 Regis	trar's Sign	ature do	and I									

			1 - For State Registrar	State of Marylar	nd / Depa	artment	of Health and of Death	Mental Hyg	9		29742
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	1	Year	3. Time of Death
	Physicia /Medic			Haywood H	E. Lof	tis		Se p	Day OS	2006	4:56 PM
	Examin	er	4a. Facility Name (If not institution, give s	-		· ·	own, or Location of Dea	th	4c. County		_
			Doctor's Community  5. Social Security Number 6. Sex		last birthday)	If Under 1	Janham Year   If Under 24 Hr.	s. 8. Date of Birth			orge's
	Funeral Director			<sup>™ 2□F</sup> 78	Yrs.	Months [	Days Hours Min				lace (State or Foreign try) h Carolina
2)	pu >		Usual Residence of Decedent		ty, Town or Lo	nation		200 207			0d. Inside City Limits
3	the Marylar 28a-f ehow	ō.	, ,		ly, fown or Lo						1 X es 2 No
Eugene	the Maryla 28a-f ehor	rect	Maryland   Prince G	eorge's		10f. Zip C	dover Hill		ng. Citizen of	What Count	try?
137	h with	ai Di	7002 Taylor Stre	et			20784			USA	
-	r deal	Funerai Director	11. Marital Status	12. Was Decedent Ever in 2	13.	Was Deceder	nt of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ce - America	
2Q 36	rs afte	y F.	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 ☐ No If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b>	No Specify:		Specif	y. Whi	te
1W00d	72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 ehow deal Examiner must be notified at	Completed by	15. Decedent's Edu	cation		dent's Usuai (			6b. Kind of B	lusiness/Ind	Justry
3 2	within 7 ene. then "n	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	ŕ	orking			
3/2	iled w hygier her th	ပိ	17. Father's Name (First, Middle, Last)			Analy		ame (First, Middle, N		vernme	ent
Hand	Mental Parked of	To Be	Thomas Koosie Lof	tis				Mamie Paq		110)	
ary Z	shoul ind M mari umati	ř	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (S	Street and Number or F			, State, Zip	Code)
, N	and 2 salth a n 27 le		Lois Loftis (Wife	·			or Street,		Hills,	MD 20	0784
4.0	ges 1 t of He if Item or oth		20a. Method of Disposition 1 Saurial 2 ☐ Cremation 3 ☐ R	enioval nom State	Place of Dispo cemetery, crei				20c. Location	- City or To	wn, State
III T	it. Pa rtmen rtent: njury		4 ☐ Donation ☐ Other (Specify)  21. Signature Ineral Service Ligense	H			metery 9/9 Address of FacilityRe		Danvi		
Ba	permit. Departm Importe eny inju		21. Signature dineral Service Ligense	Paul 1			napolis Ro	•			lie
7			23a. Part1. Enter the disease, or combination of the shock, or heart faiture. List only or	cations that caused the deal							Approximate Interval Between
	Physician	_	Immediate Cause (Final disease or condition	NON HO							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						2WKS
	Lxammer	<u>.</u>	Sequentially list conditions,	PNEUM Due to (or as a consec		†					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SEPSI							iwk
o,	le be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a consec	quence of):						
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x 68	certificat anding phy use as th	/Mec	IF FEMALE:	3c. If yes, outcome of pregn	ancy				201.0		17,000
Bo	death atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	aldeath 3	Ectopic preg				ite of deliver onth	ry Day Year
P.O. Box	that the deed by the	by Physician/Med	9 Unknown	9□ Unknown							
	res tha iigned be de		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cau	se given in Part I.		/		e cause of death?
ord	w requir been si should	eted						1 🗆 Ye			ably 4 □Unknown
Rec	The law ete hes t page 2 s	Completed						24a. Was ar autopsy perform	/	Were autop prior to con death?	osy findings available apletion of cause of
tal	iclan: Th	e Co	25. Was case referred to medical				26 Place of Do	1 ☐ Yes 2 eath (Check only one		1 🗆 Yes	2 No
Ξ	Physiclan: this certific al director,	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatier	at 3□ DOA	Othor	Home 5 Reside		ner (Specify	
0	Jing Ph J. After th funeral	on;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	_ 1	. Injury at Work?	28d. Describe ho	w injury occui	red	
Division of Vital Records,	Attendi death. ctor: A y the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome form at	M factory o	1 ☐ Yes 2 ☐ No	28f. Location (Str	and Alumi	has as Rumi	Coute Number
Div	after of Atlanta	ertif	4 Homicide determined	building, etc. (Speci		eet, ractory, c	mice	City or Town	State)	per or murai	Houle Number,
	<ul> <li>Hospitel or Attending Physician: The law requires that the death certifica 24 hours after death.</li> <li>Phours after death.</li> <li>Funeral Director: After this certificete hes been signed by the attending philetely filled in by the funeral director, page 2 should be detached for use as the</li> </ul>	Medicai C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, deat ation and/or in	n occurred at vestigation, in	the time, date and place my opinion, death occ	e, and due to the ca curred at the time, da	use(s) and m te and place,	anner as sta and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		1111	29c. L	icense number	29	d. Date signe	d (Month, D	Day, Year)
	$\bigcap$		Harhad !	Jamese	MI)	2	0058	213	9/6	120	206,
OR_	(10)		30. Name and address of person who confidence of the confidence of	mpleted cause of death (Item M) 7305	m 23a) (Type,	Print) Over t	OKNY G	recubel	t MD	207	70
	Sta Registr	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	5					

			- vediana	State of Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of He	ealth an Death		Heg. No.	200	
	Physici /Media	cal		se Logullo		1, 0	T			ember	6,200	
	Examir	ier	4a. Facility Name (If not institution, give si 606 Dr. Jack R 5. Social Security Number 6. Sex	Road	last hirthday)	Por	t De	ocation of D posit If Under 24	;		County of Deat	h hplace (State or Foreign
	Funeral Director				62 Yrs.	Months			Win. OCt.	Birth Day, Year) 27,1	943 P	ennsylvani
	ith the Maryland or 28a-1 show	Director	10a. State 10b. County  Delaware New Ca  10e. Street and Number		ty, Town or Lo	Ne	wark			-	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
350	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or itams 23a or 28a-f show avent, Ira Madical Exertical must be notified at	by Funeral Directo	82 Gypsum Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1		Was Dec If Yes, sp			? (Specify Yes or uerto Rican, etc.)	No- 1	S.A.  14. Race - Ame Black, Whit Specify: WI	e, etc.
21215-0036	vithin 72 hou ne. han "natura e Masical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	kind of w DO NOT	use retired)	iring most of		Int	erstat	te 95
Maryland 21	e d ia b	To Be Col	Twelve Years   17. Father's Name (First, Middle, Last) Robert Ansl	ey Chamber		OTT		ector	name (First, Midd Virgin:	ile, Maiden .	Sumame)	<u>Delaware</u>
	s 1 and 2 should be if Health and Mental itam 27 is marked other treumatic sv		19a. Informant's Name/Relationship (Type Laurie M. Bine	es (Daught	er)	606	Dr.		Road,	Port	Depos	
Baltimore,	m 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State R .		matory or rris	other place I & CO.	nc.09	Date 9/06/06		cation - City or Chest	Town, State
g	permit. Page Department importent: If eny injury o		21. Signature of Funeral Service License  23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	(12 H 12 1	T.	ee 7	and Address A. Pa /vill	tters	son & So	on Fu 2190	neral 3-076	Home, P.A
	Physician /Medical Examiner		shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Metastatic  Due to (or as a consec	Chel			None		411651,		Approximate Interval Between Onset and Death
3/60,	ate be executed hysicien and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec								
٥	death certificate e attending physi d for use as the	Medical	d.		-							
.O. Box	at the death certific by the attending p tached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of centre of the properties of the pregnant at time of the pregnant a	ıl death 3 [	⊒Ectopic   ⊒ Other (s	oregnancy specify)			- 2	3d. Date of del Month	ivery Day Year
ecords, P.	The law requires that ste has been signed b sage 2 should be deta	þ	Part If. Other significant conditions cont	tnbuting to death but not res	sulting in the u	nderlying	cause given	in Part I.		d tobacco us		the cause of death?
r		Completed						-	24a. Wi au pe 1 ☐ Yes	topsy rformed?	prior to death?	topsy findings available completion of cause of
VIT 2	ysician: is certifice director, p	To Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 🖸			Death (Check onling Home 5 Re		Daug	ter's
DIVISION OF	Attending Physician: r death. ector: After this certificator, the funeral director.	Certification; 7	27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f M	28c. Injury a Work?	at es 2⊡No	28d. Describ			
	in Sir o		3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	<i>(</i> y)				City or 1	Town, State)		iral Route Number,
	To the Hospitel within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier 1 Certifying Physical Control 2 Medical Examin	icien: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or in	h occurre vestigatio	d at the time n, in my opii	e, date and p nion, death o	lace, and due to the control of the time	e, date and	and manner as place, and due	stated. to the cause(s)
)	with To t	Σ	29b. Signature and title of certifier				oo4			1	signed (Monti	6, Day, Year)
	8		30. Name and address of person who cor	1-306 North	Street		(ite#:	3 ELY	AY NOTS			
\$7	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	door	W					

			1 - For Stete Registrar	State of Man		artmen ertificate					ene 2	006	29	744
	Dii.i.i		1. Decedent's Name (First, Middle, Las	)					2.	Date of Death Month	Day	Year	3. Time of	Death
	Physici /Medio		Joseph Spencer	Linkins						August		2006	9:26	a M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or L	ocation o	of Death		4c. Cou	unty of Death		
			Montgomery Gener				Q	lney					omery	
	Funeral		5. Social Security Number 6. Se	x 7. Age (i ⊒M 2□F	In yrs. last birthda	/) If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	rear)	Cour	place (State o	-
	Director		577-28-2245 Usual Residence of Decedent		84 Yrs.				Ap	ril 13,	192	2 Wash	ington	, DC
	and and		10a. State 10b. County	1	0c. City, Town or	Location						1	0d. Inside Ci	ty Limits
	Mary	ō	Maryland Montgon	lerv	Sil	ver Sp	rina						1 ☐ Yes	2 🔯 No
	ith the Marylar or 28a-1 show to notified at	Director	10e. Street and Number	icry	DII	10f. Zip				10	g. Citizen	of What Cour	ntry?	
	23a o	Ö	15300 Pine Orch	ard Drive,	Apt. 2D		20	0906			US	A		
	deatl	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?			lent of His	panic Orig	gin? (Specif	y Yes or No- an, etc.)		Race - Americ		
9	after or Ite		1 ☐ Never Married 2 ☐ Marned	1 TVes 2 No		1  Yes 2			i, Fuerto Filo	ALII, OIG./	i	Black, White, ec <i>if</i> y:Whit		
21215-0036	72 hours after death with the Maryland "netural", or itema 23e or 28e-1 show waltel Extrainment that the motified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:WW							Spe	schy.WIII C	e	
5	- 4 10	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dec (Giv	edent's Usua e kind of wor DO NOT us	l Occupat k done du	ion <i>iring</i> mo <i>st</i>	t of working	1	6b. Kind o	of Business/In	du <i>s</i> try	
12	within ene. then "	m D	Elementary/Secondary (0-12)	College (1-4or 5+)										
7	filed Hygie other ant.	e Co	17. Father's Name (First, Middle, Last)			arpent		18 Mothe	r's Name /F	First, Middle, M		esiden	tial	
Maryland	d be	To Be	Clayton William	Linkins						line Ca			neter	
Z	should bud Ments marked	ĭ	19a. Informant's Name/Relationship (T		19b. Ma	ling Address	(Street an	nd Numbe		loute Number,				
N S	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any Injury or other traumatic event. If a Mance.		Ronald M. Linkins			_				Mississ	-		,	
Baltimore,	s 1 ar f Hea ftem othe		20a. Method of Disposition		20b. Place of Dis	oosition (Nameratory or o	ne of		Date	9 2	Dc. Locati	on - City or To	own, State	
ê E	Page onto		1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	Removal from State	Arlington	-			Sept.	2,				
alti	oorta		21. Signature of Funeral Service Licens						2006	uneral	Ting	ton, V	ırgıni	a
Ö	Depar Depar Impor any In		1 (inland	I le		500 Un	ivers	sity	Blvd,	W, Sil	ver	Spring	, MD 2	0901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	e death. Do not e	nter the mode	e of dying,	such as	cardiac or re	espiratory arres	it,		Approximate Interval Bets	eween
	Physician		Immediate Cause (Final disease or condition	,	Ancho	R_) a	1.8ラ						Onset and D	Death
1	/Medical		resulting in death)	a Due to (or as a o	onsequence of):	(- /0	(	- (					45-0	
	Examiner		Sequentially list conditions	b	150 can	کارد ا	Duta	with	on					
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a c	consequence of):									
	and -trans	Examiner		c	consequence of):									
8760,	ate be executed hysicien and the burial-transit	E E		Due to (or as a c	consequence or):									
87	physis the	Physician/Medical	•	d										
9 x	The law requires that the death certifics to has been signed by the attending phage 2 should be detached for use as it	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy						224	Date of delive	2004	
Вох	atter atter I for L	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ( 4 ☐ Pregnant at tim		☐ Ectopic pre					200.	Month	•	/ear
P.O.	that the de ned by the a detached f	ysi	1 Yes 2 No 9 Unknown	9□ Unknown										
	uires that signed b	by PI	Part II. Other significant conditions co	ntributing to death but r	not resulting in the	underlying ca	ause given	in Part I.		23e. Did toba	cco use o	contribute to th	ne cause of d	eath?
rds	w require been sig should b	pa pa	fect	Renal F	ailure					1 🗆 Yes	2 🗆 N	o 3□ Prob	ably 4 🗆 U	nknown
တ္တ	s bee	ojet								24a. Was an	24	b. Were auto	psy findings a	available
æ	The I	Completed								autopsy performe 1 ☐ Yes 28		death?	mpletion of ca	luse of
of Vital Records,	sicisn: The law certificete has t irector, page 2 s	0	25. Was case reterred to medical					26. Place	of Death (C	Check only one			2010	
<b>_</b>	Physicism: this certifice ral director, I	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpati	ent 3 DO	A Other	4 🗆 Nur	rsing Home	5 🗆 Residen	сө 6 □	Other (Specify	v)	
0	ding Pt h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time Injury	of 2	8c. Injury a Work?	at	280	I. Describe how	injury oc	curred		
sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Ye	s 2 🗆 N	· · · · ·					
Division	or Attending after death. Director: After in by the fune	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, s 'Specify)	treet, factory	, office		28f.	City or Town,		umber or Rura	l Route Numi	ber,
	pital urs a aral [		One Continue and Continue Physical Phys	Parising Total Control										
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of r iner: On the basis of ex and manner stated	camination and/or	investigation,	in my opir	nion, deat	d place, and th occurred	I due to the cat at the time, dat	ise(s) and e and pla	l manner as si ce, and due to	tated. the cause(s)	)
	ithin o the omple	Me	29b. Signature and title of certifier	1	-	29c	. License	number		290	d. Date sig	aned (Month,	Day, Year)	
			> Robert Inters	to, mo			DUIT	277	7	A	700 -	1	2006	
(	otl		30. Name and address of person who o	ompleted cause of deat	th (Item 23a) (Tyro	Print)	21	- / /	-		- 'D'43			
			Richard Weinste	m 18100	7 Prince	Di I	p Dr	14	010	ey, Mo	Ma	d 20	8 32	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Régistrar's		houst.	,			1				
	Registr	ar	SEP 05	2006	U S. Y	The state of the s								

06-06454

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene 2006 29745 Sean Loughery

		1- For State Registrar		C	ertificat	e of i	Death				F	Reg. No.	_	UU	0	29/4
Physici		1. Decedent's Name (First, Midd	Decedent's Name (First, Middle,Last)							2.	Date of De	ath	.,		3. Time of I	Death
ledical Exami	ner	Sean Michael	Loughery	,							Month August 2	8, <sup>Day</sup>	Year		1415 h	nrs
		4a. Facility Name (if not institution 1211 Light Street	on, give street and nu	umber)		41:	Baltimor		ocation o	f Death		4c. C	County of	Death		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthd	ay)	If Under 1	_	If Under		8. Date of B	irth (MM/DI		9. Birth Foreigr		e or
Director		214-94-0052	1 XM 2 F		28	Yrs.	Months	Days	Hours	Min.	March1	14,19	78	Ma	yland	d
		Usual Residence of Decedent								-ll						
v any		10a, State 10b, County			ty, Town or		n									City Limits
and sho	5	Maryland		B	altim	ore									1 X Yes	2 No
, MD 21215-0036 sand 2 should be filed within 72 hours after death with the Maryland health Hygiene. them 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1211 Light Str	eet			1	10f. Zip Co 21	de 1230	)			10g Citize Un:	ited	t Count Sta	<sub>ry?</sub> ates	
with ns 23.	<u>ra</u>	11. Marital Status		cedent Ever in	U.S. 1						ify Yes or N	0- 14			an Indian, E	Black,
death or iter	Funeral	1 X Never Married 2 N	larried Armed F	orces?			s, specify C			Puerto Ri	can, etc.)		White,	etc.		İ
after al", c	by F	3 Widowed 4 Div	vorced If Yes, Give 1et	995-199	96	1 📗 ነ	res 2 🛚	No :	specify:			S	ecify.		√hite	
hours afte 'natural'' Examine		15. Decedent's Education (Spe					s Usual Occ st of working					16b. Kın	d of Busi	ness/In	dustry	
n 72 h	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	Pair	-		, =			-,	Α,,,	tomo	+ i x 7/		
5-0036 led within 72 Hygiene. other than the Medical	Ĕ				Tan	ILCL		Lia						CIVE	<del></del>	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	BeC	17. Father's Name (First, Middle Keith C. Lough									irst, Middle, Manue		ırname)			
ore, MD 2121; I and 2 should be fil of Health and Mental F If item 27 is marked ner traumatic event,	ပ	19a. Informant's Name/Relations Keith C. Lough	19b. I	Mailing A	Address (	Street a	and Numl	ber or Rur	al Route Nu Mary	mber, City	or Town,	State,	Zip Code)			
and 2 shou lealth and N tem 27 is n traumatic	_	20a. Method of Disposition	101) 1001		o. Place of I					,	Date				own, State	
Baltimore, M mit. Pages I and 2 epartment of Health Important: If item 2 injury or other traum		1 X Burial 2 Crematio	n 3 Removal f	01-1-	crematory <b>ESUTT</b> (	or othe	r place)		- 1						arylar	
ti Pag tment rtant		4 Donation 5 Other S		IN	esurre									•	_	
3al epar mpon		21. Signature of Funeral Service	Cicensee	1		130h	aid A	ress B	orgw	ardt	Funei	al H	ome,	PA		120705
D	. //	3a. Part I. Enter the disease, or	) a geva	ausad the dea	oth Do not o											ate Interval
Physician /Medical		failure. List only one cause	e on wich line.				e inicate a a	yirig, su	icii as ca	ardiac or re	espiratory ar	lest, shock	, or near	1	Between	Onset and
€xaminer		Immediate Cause (Final disease or condition resulting in death)		unshot Wou consequence		nest								-	De	eath
			b Due to (or as a	a consequence	e OI).											
	ē	Sequentially list conditions, if any, leading to immediate		a consequence	e of):										-	
_	Examiner	cause Enter Underlying Cause (Disease or injury that initiated	C													
cuted and transit	Exa	events resulting in death) Last		a consequence	e of):											Î
xecute n and  - trar		UNPENDED	dAMENDED							-						
760, icate be exe physician a	Physician/Medical															
8760, tificate be ng physici as the buri	N/	IF FEMALE: 23b. Was decedent pregnant in t		outcome of projects	-	Eata	death	3	Ectonic	pregnanc	v		Date of de onth	-	ıy	Year
Sox 687 leath certific e attending J for use as t	cia	past 12 months?		nant at time of			er (Specify)		Lotopio	programo	,	"	Ortar		, ,	TCB1
Box 68 e death certi the attendin	iysi	1 Yes 2 No 9 Un	known 9 Unkn	own			, (-,,									
P.O.		Part II. Other significant condi	tions contributing t	o death but no	t resulting it	the un	derlying cau	use give	en in Par	t I.	23e. Did 1	obacco us	e contribu	ute to th	e cause of	death?
res that signed '	d by										1 Ye	s 2 🗸 N	10 3	Proba	bly 4	Unknown
cords, law requir has been s	Completed										24a. Was				psy finding	
e law e has ge 2 s	Ē										perfo	rmed?	de	ath?	mpletion of	_
tal Rec		25 Was case referred to medica					26.5	Place of	E Dooth /	Check onl		2 No	1	/ Yes	2	No
Tital sician is cert	a	examiner?	Hospital:	Inpatient 2	ER/Outp	atient			hor —	Nursing I		Residenc	0 6 . 1	Othor	Scono	
of Vital Records, ing Physician: The law requir After this certificate has been si uneral director, page 2 should b	2	1 Yes 2 No 27. Manner of Death			28b. Tir				at Work?		3d. Describe	•			3cene	
on Control of the African Afri	ion	1 Natural 5 Pen		of Injury Day,Year)	FOUN	D:	·   ,		s 2 🗸	Si	ubject sho					
isic Atte rector	icat		estigation Aug 28, 28e. Place	, 2006 ce of Injury - At	1400 h	_	factory off	ice buil	ding etc	28	3f. Location (	Street and	Number	or Rurs	I Route Nu	mher City
Division pital or Attendio ours after death teral Director: Affiled in by the fu	ertification:	dete	ia not be	residence		,			an ig, o is	- 1	or Town,	State)				riber, ony
Hospital 24 hours Funeral tely fillec	O	29a. Certifier 1 Certifying P	hysician: To the be			OCCUE	d at the tim	e date	and plac							
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Trans.	Medical	(Check only	aminer: On the basis and manner	of examination	-											
F 3 F 8	Re	29b Signature and title of certifi		0			29c. Li	cense r	number			29d. Da	te signed	(Mont	h, Day,Yea	r)
4		HI.	- Yal	le	~		0	.C.M.	Ε.			Augus	st 29, 2	2006		
	1	30. Name and address of person	n who completed cau	se of death (Ite	em 23a)											
		Patricia Aronica-Polla		ant Medica		er	111 Penr	Stre	et, Bal	timore,	MD 2120	11				
						100										
Si Regis	tate	31. Date filed (Month, Day, Year)	5 2006 32 A	egistrar's Signa	atur	100										

			1 - State State Registrer		rtment of Health and tificate of Death		ene 2006 29741
	Physici		Decedent's Name (First, Middle, Last)     THEODORE MCCA	TN		2. Date of Death Month SEPTEMBE	Day Yeer 3. Time of Death 11:39P M
j	/Medic Examin		4a. Facility Name (If not institution, give street and n		4b. City, Town, or Location of Deat		4c. County of Death
			17 LAUGHTON STREET		UPPER MARLBORO		PRINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex 1⊠ M 2□ F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Y	9. Birthplace (State or Foreign Country)
	Director		238-36-7120	01 113.		JAN 26	1925 NORTH CAROLINA
	yland		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	e-f st	tor	MD PRINCE GEORGE'	S UPPER MA	RLBORO		1 X Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
	death with the Maryland ms 23a or 28e-f show Finust be rediffed at		17 LAUGHTON STREET		20772	N	U.S.A.
36	I within 72 hours after death with the Marylan liene. I than "natural", or items 23a or 28e-f show I'lla Mudical Examinat must be notified at	by Funerai	11. Marital Status  1 Never Married 2 X Married  1 Never Married 2 X Married  3 Widowed 4 Divorced  12. Was De Ammed 1 X Yes If Yes, C	$\frac{2}{9}$ $\frac{2}{5}$ $\frac{2}{9}$ $\frac{2}{5}$ $\frac{2}{5}$ $\frac{2}{5}$ $\frac{2}{5}$ $\frac{2}{5}$	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer I ☐ Yes 2☑ No Specify:	to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK
215-0036	2 hou	ted	15. Decedent's Education		lent's Usual Occupation kind of work done during most of wo	rting 16	6b. Kind of Business/Industry
2	within 72 ene. than nai	Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+) life. L	OO NOT use retired)		
N	filed wi Hygien other th	် ပ	12th	SUP	ERVISOR		GOVERNMENT
and	a d la b	Be	17. Father's Name (First, Middle, Last)  ELBERT MCCAIN		CORA	me (First, Middle, Ma A. GRAVES	
$\geq$	should nd Mer marke	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or R		
<u>8</u>	ha ha 7 te		JEWEL MCCAIN/WIFE				ORO, MARYLAND 20772
ē,	s 1 and of Healt item 2 other		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date 20	c. Location - City or Town, State
Ē	Pages nent of ant: If it ury or o		1 ⊠Burial 2 □ Cremation 3 □ Removal fror 4 □ Donation 5 □ Other (Specify)	m State MARYLAND	VETERANS 9/8/		HELTENHAM, MARYLAND
saitimore,	permit. Pages 1 Department of H Important: If ite eny injury or oth		21. Signature of Funeral Service Licensee	1.0			KINS FUNERAL HOME
"	80E#3		23a. Part1. Enter the disease, or complications that	Jef	474 LANDOVER ROA		
į	Physician /Medical Examiner		shock, or heart failure. Lifst only one cause or Immediate Cause (Final disease or condition resulting in death)  a. Due to	o (or as a consequence of):	lancer, Lung Hetast		interval Between
8/60,	ate be executed obtaining and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequence of): o (or as a consequence of):			
O. Box 6	ath certific ittending p or use as	Physician/Mec	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
Vital Hecords, P.	quires that the de n signed by the a uld be detached f	Ď	Part II. Other significant conditions contributing to	death but not resulting in the un	nderlying cause given in Part I. Lutter		cco use contribute to the cause of death? 2 □ No 3 ☑ Frobably 4 □ Unknown
Ö Ö	aw requir is been si 2 should l	Completed	Chronia Ren	al Insuff	i ciency	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ĭ		Som.	Hypertension	- ),	0	performe	death?
<u> </u>	sicien: The law certificate hes l irector, page 2 s	Be (	25. Was case referred to medical examiner?			ath (Check only one)	
5	Physic this cral dire	ပ္		Inpatient 2 ER/Outpatien			ce 6 ☐Other (Specify)
S C	ding F h. After funera	lon	1 Natural 5 Pending (Mo	e of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	rinjury occurred
Division of	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, str Iding, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	(Check only 2 Medical Examiner: On the	he best of my knowledge, death basis of examination and/or invanner stated.	o occurred at the time, date and place restigation, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	\	29c. License number	290	d. Date signed (Month, Day, Year)
)	$\Omega$ 1		1 minulde		041945		09/01/06
R	6/1/0		30. Name and address of person who completed ca CIELITO AGUINALDO M.	use of death (Item 23a) (Type, D. 1221 MERCAN	Print) TILE LANE LARGO,	MARYLAND	20774
k	Sta Registi	ate rar		Registrar's Signature	U		

State of Maryland / Department of Health and Mental Hygiene 2006 29747 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 2, **Physician** Townshend Miller Miller Dorothy 2006 3:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Center Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 27, 19 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2√€3√F Director 1910 Washington, 577-01-9681 Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23s or 28a f ehow empiry or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Prince George's Temple Hills Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20748 3606 28th Parkway by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 XXX6 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Helen Kirby Clayton Townshend ဥ Edgar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12804 Windbrook Dr. Clinton, Maryland Harold C. Townshend / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 109/07/2006 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Pant. Enter the disease, or complications, or heart failure. List only one ods that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown Demenho 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1☐ Yes 2 X No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) surratts Rd. clinten mo suresh A Pateino 31. Date filed (Month, Day, Year) SEP 0 6 2006 State Registrar

06-06562 William Middleton

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 29748

		1- For State Registrar		ate of	Death			Re	g No.	00	0 2314	
Physic dical Exam		1. Decedent's Name (First, Midd		IDDLETO	N			ΙN	ate of Death Month eptember	Day Year		Time of Death 0137 hrs
N		4a. Facility Name (if not instituti 5361 Sheriffs Road				b. City, Town, o			epterriber	4c. County o		
		5. Social Security Number	6. Sex 7. Age	(In yrs. last birt	·hday\	If Under 1 Ye		r 24Hrs 8	Date of Birt	h(MM/DD/YYYY)		
Funera Director		578-06-3097	1 X M 2 F 24	, ,	Yrs.	Months Da		Min		28 1982		ASHINGTON DC
in.		Usual Residence of Decedent  10a, State  10b, County		10c. City, Town	or Locatio	20					1 11	Od Inside City Limits
ow any						211					1	X Yes 2 No
yland a-f sh t once	ફ	MD PRING  10e. Street and Number	CE GEORGE'S	LAND	OVER	10f. Zip Code			110	g Citizen of Wh		
15-0036 He within 72 hours after death with the Maryland Hygiene dother than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at once.	Director	9045 CONGRESS	PLACE			207	85			U.S.A		
ath with tems 2: st be no	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Decedent I Armed Forces?			Decedent of H es, specify Cuba				14. Race White		n Indian, Black,
ter dea	l I	3 Widowed 4 Di	vorced If Yes, Give Year	No	1	Yes 2X N	o specify:			Specify:	BLAC	r I
2 hours afte "natural", Examiner	g P	15 B - 1 - 1 - 1 - 1 - 1 - 1 - 1	or Dates:			's Usual Occup			done	16b. Kind of Bus	-	
72 ho	ete	Elementary/Secondary (0-12	) College (1-4 or 5	+)	_	ost of working lif	e. DO NOT i	use retired)				
5-0036  led within 7  Hygiene lother than the Medica	Completed	12th			CL	ERK				PRIVA		
filed I Hyg	Be C	17 Father's Name (First, Middle WILLIE JAMES N						IA T.		laiden Surname) CMTTH		
21215-00; buld be filed with Mental Hygiene marked other t	To B			b. Mailing	Address (Stre				ber, City or Town	, State, Z	ip Code)	
AD 2 sho h and 27 is	-	LATOYA MIDDLE	CON/SISTER	90	045 0	CONGRESS	PLAC	E LAN	DOVER,	, MARYLA	ND 2	20785
re, M s Land 2 of Health If item 2		20a Method of Disposition  1 X Burial 2 Crematic	on 3 Removal from Sta		of Dispository or oth	tion (Name of c er place)	emetery,	Da	ite	20c. Location ~	City or To	wn, State
Pages I nent of H ant: If it		4 Donation 5 Other S			ONY C	EMETERY		9/8/2		LANDOVI		
Baltimore, permit. Pages I an Department of Her Important: If ite		21. Signature of Funeral Service	e Licenpee			ame and Addre	-			NKINS FI		
	_	23a. Part I. Enter the disease, of	or complications that caused	he death. Do no						ER, MAR		20785 Approximate Interval
Physiciar /Medica		failure. List only one caus	e on each line.			,	,					Between Onset and Death
Examine	r	Immediate Cause (Final dishas or condition resulting in death)	Due to (or as a conse								$\neg$	
	L	Sequentially list conditions,	b								-	
	Ę.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	quence or);								
ed	Examine	events resulting in death) Last	Due to (or as a conse	quence of):	-							
3760, ficate be executed g physician and sthe burial - transit	n/Medical	UNPENDED	a AMENDED									
8760, ifficate be ng physicils the buri	Je	IF FEMALE:	23c. If yes, outcom							23d. Date of	delivery	
	3 I 느	23b. Was decedent pregnant in past 12 months?	Live Ditti	inca at alamete			Ectopic	pregnancy		Month	Day	Year
Box 68 e death certi	Physicia	1 Yes 2 No 9 U	nknown 9 Unknown		3 [] Otr	ner (Specify)				4		83
P.O.			itions contributing to death	but not resultin	ig in the u	nderlying cause	given in Pa	rt I.			_	cause of death?
S, P.C uires that in signed	edt							- 1				uly 4 Unknown
ords aw requires as been	Completed						_	1	24a. Was a autop: perfor	sy p		osy findings available inpletion of cause of
ician: The law icentificate has be certificate has be	9								1 Yes 2		<b>✓</b> Yes	2 No
ician: certif	B B	25. Was case referred to medic examiner?	Hospital: 1 Inpatie	- 1 TEB/0	Outpatient		Other	(Check only Nursing Ho		Residence 6	Other: C	
n of Viding Physical After this	B   F		28a. Date of Inju	ry 28b.	Time of Ir		ury at Work			now injury occurre		cerie
ion ( tending eath. tor: Af	ij	1 Natural 5 Pe	nding Sep 2, 2006	o13	5 hrs	1	Yes 2	No Sub	oject was	shot		
Division of Vital Records,  Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si	<u>ଃ   :ଓ</u>	2 Accident Inv 3 Suicide 6 Co	estigation 28e. Place of Inj	ury - At home, f	arm, stree	et, factory, office	building, etc	c. 28f.	Location (S		r or Rural	Route Number, City
Dipital ours a neral E	e l	4 / Homicide det	ermined (Specify) Par	king Lot				536	S1 Sherif	f Road, Capi	tol Heig	hts, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician; The law requires that the death certivithin 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attendin completely filled in by the funeral director mane 2 should be detached for use as		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date of the date of										
To the within To the	Med	29b. Signature and title of certification		29c. Licer	nse number			29d Date signe	ed (Month	, Day, Year)		
~	Mhora Brassell M.D.					0.0	M.E.			September	2, 2006	5
0 (15)	1	30 N me and address of person		eath (Item 23a)								
2	O.	Melissa Brassell, MD				enn Street,	Baltimore	e, MD 212	201			
	State	31 Date filed (Month, Day, Yea.	r) 2. Registra	's Signature	hard	1						

			For State	State of Mary	land / Dep		Health and M	Mental Hygi	ene 200	5 29749
	Physici	ian	Registrar  1. Decedent's Name (First, Middle, La	,		inicate of	Deain	2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Duffy Newell Mcl 4a. Fecility Name (If not institution, given			Ab Ciby Town	or Location of Death		27 2006	
	Examir	ner	Coastal Hospice			So. Lie	1		4c. County of Deat	
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In	yrs. last birthday			8. Date of Birth	0 Pid	hplace (State or Foreign
	Director		263-20-3304 Usual Residence of Decedent	1 <b>X</b> M 2□F 8	O Yrs.	Months Days	Hours Min.	Feb. 7,1	926 Flor	intry) ida
}	nyland how		10a, State 10b, County	100	. City, Town or L	ocation				10d. Inside City Limits
4	8a-f	ctor	Maryland Wicomic	0	Fruitla	nd				1 X Yes 2 No
Z	with th	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	untry?
Exe	ns 23	Funeral	315 East Main Str	12. Was Decedent Ever	in U.S.   13		826 Hispanic Origin? (Sr	acify Yes or No.	USA 14. Race - Ame	ocan Indian
920	be filed within 72 hours after death with the Maryland ital hygiene. od other than "natural", or Itams 23a or 28a-f ahow avent, the Medical Examinar must be motified a	by	1 Never Married 2 X Marned 3 Widowed 4 Divorced	Armed Forces?  1 ∑Yes 2 □ No If Yes, Give Year or Dates:	1943- 1964	If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc.
Baltimore, Maryland 21215-0036	hin 72 ho a. Medical	Completed	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Giv. life.	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of work ad)	sing 16	6b. Kind of Business/	ndustry
2	filed wit Hygiene ther the	Con		2	Tead	cher			Education	
and	2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -	Be	17. Father's Name (First, Middle, Last					e (First, Middle, Ma	,	
Š	should be ind Mental marked o umatic ava	2	James Alonzo McK  19a. Informant's Name/Relationship (		10h Mail	ing Address (Street		rie Newel	.1 City or Town, State, 2	Via Code)
⊠	es 1 and 2 should be of Health and Ment filam 27 is marked rother traumatic a		Rachel McKenzie/						yland 218:	F
Je,	as 1 a of Hea itam		20a. Method of Disposition	20		osition (Name of omatory or other pla			c. Location - City or	
Ë	Pages ment of ant: if it ury or o		1   Burial 2 □ Cremation 3 □  Donation 5 □ Other (Special Control Con	31101110481110111 01810	_	s UMC Cer		/2006 F	ruitland,	Maryland
Balt	permit. Pages: Department of Plimportant: if its any injury or of specific and spec		21. Signature of Funeral Service Line	Selle		2. Name and Addre eller Fur 212 Old C	ess of Facility neral Home Ocean City	P. O. I	Box 3171 alisbury,	MD 21802
	Physician /Medical Examiner		Asa. Pan1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Metasted the consequence on each line.  Due to (or as a consequence)	ic Ly	iter the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a con						
68760,	eath certificate be executed ettending physicien and for use as the burial-Iransit	cal		d.	saquence on.					
P.O. Box 68	requires that the death certifical een signed by the ettending ph hould be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deli Month	very Day Year
rds, P	quires that n signed t	þ	Part II. Other significent conditions of	contributing to death but not	resulting in the u	underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Reco	e law has b	Completed						24a. Was an autopsy performe	d2 prior to c	topsy findings available ompletion of cause of
ita	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes 2	No 1 ☐ Yes	70110
<u></u>	hysic this ce al dire	2	1 Yes No		2 ER/Outpatie	" 30 DOX			ce 6 □Other (Spec	ify)
Ę	Jing P	ion:	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor		28d. Describe how	injury occurred	
Division of Vital Records,	or Attancetter death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e Zon Dinen et laine	At home, farm, st ecify)		]Yes 2 □ No	28f. Location (Stree City or Town,	et and Number or Ru State)	al Route Number,
_	To the Hospital or Attending Physicien: within 24 hours efter death. To the Funerei Director: After this certific completely filled in by the funeral director.	Medicai C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, dea nination and/or in	th occurred at the tin	me, date and place, opinion, death occur	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	000		29c. Licens		29d	. Date signed (Month	, Day, Year)
			THE	CC, N		Do	36278		8-25-	.66
_			38 Name and address of person who	11. NO Cas	Hal Hos	Print)	0 Box 173	3 Seels	ch MO	21802
	Sta Registr	_	31. Date filed (Month, Day, Year)	0 2006 Registrat's S	ignature	Speeds	,		),	

06-06606

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State	/ Department of Certificate of			2006 2975
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Michael Lee Mont	gomerv		2. Date of Deat Month Septembe	th 3. Time of Death
	4a. Facility Name (if not institution, give street and number) 445 McCauley Road		b. City, Town, or Location of		4c. County of Death Cecil
Funeral Director	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)		1 Mars	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)
	Usual Residence of Decedent	50 Yrs.		Dec. 3	
d how any.	10a. State 10b. County  Maryland Cecil	10c. City, Town or Locati	on Conowingo	2	10d. Inside City Limits  1 Yes 2 X No
the Marylanc a or 28a-f sh	10e. Street and Number	L	10f. Zip Code	11	0g. Citizen of What Country?
vith the 3 23 a or 23	308 Johnson Road  11. Marital Status 12. Was Decedent	Ever in U.S. 13. Was	2191 s Decedent of Hispanic Orig		U.S.A.  14 Race - American Indian, Black,
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2 X Married Armed Forces?	X No	es, specify Cuban, Mexican, Yes 2 X No specify:	Puerto Rican, etc.)	White, etc. Specify: White
"natura Examin	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)  College (1-4 or a secondary 10-12)	during me	's Usual Occupation (Give lost of working life, DO NOT		16b. Kind of Business/Industry Mike Montgomery Auto, Inc.
5-0036 led within 72 hour Pygiene. other than "natu to Medical Exau Completed	Twelve Years		mer/Operator		Colora, Maryland
215-0 be filed w ntal Hygin rked othe ent, the 1 Be Co	17. Father's Name (First, Middle, Last)  Lewis Ivan Montgomery	, Sr.	18.Mother	s Name (First, Middle, M Norma Jea	
Should bend is marl is marl	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Street and Num ohnson Road,		nber, City or Town, State, Zip Code)  Marvland 21918
e, MD I and 2 sho Health and item 27 is	20a. Method of Disposition	20b. Place of Disposi	ition (Name of cemetery,	Date Date	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Speqify:	West Notting	gham Cemetery	09/08/06	Colora, Maryland
Balt permit. Departi Import injury	21. Ignature of Funeral Service Libensee	Le Pe	rryville, Mar	on & Son Fu cyland 21	neral Home, P.A. 903-0766
Physician /Medical	23a Part I. Enter the disease, or complications that caused failure. List only one cause on each line.  Multiple laiving		ne mode of dying, such as ca	ardiac or respiratory arre	est, shock, or heart Approximate Interval Between Criset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a constitution)				
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):			
uted d ansit Examiner	events resulting in death) Last  Due to (or as a const	equence of):			
50, te be executed system and burial - transit	UNPENDED AMENDED				
X 6876 ath certifica attending ph or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown	2 Fet	tal death 3 Ectopio	pregnancy	23d. Date of delivery  Month Day Year
P.O. Bc ss that the deagned by the a detached for by Phys	Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderlying cause given in Pa		bacco use contribute to the cause of death?
Is, P.( quires tha en signed and be det				1 Yes	an 2 V No 3 Probably 4 Unknown
of Vital Records, P.O. imp Physician: The law requires that the After this certificate has been signed by finneral director, page 2 should be detach on: To Be Completed by P.				autop perfor 1 🖊 Yes	sy prior to completion of cause of med? death?
Vital ysician: his certi director	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatie	ent 2 ER/Outpatient	26.Place of Death		Residence 6 🗸 Other: Scene
on of vending Ph ath. or: After t the funeral	27. Manner of Death  1 Natural 5 Pending  28a. Date of Inju.  (Month, Day York)  Sep 3, 2006	(ear) 28b. Time of Ir 1935 hrs	njury 28c. Injury at Work	المستنصم مقاسا	now injury occurred ick up_rolled_over and ejected
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune Medical Certification:			et, factory, office building, etc	or Town, S	Street and Number or Rural Route Number, City tate) ey Road , Conowingo , Md.
To the Hosp within 24 hou To the Func completely fi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of mone) 2 Medical Examiner: On the basis of examiner and manner stated				
Tr wiwi Tr	29b. Signature and title of certifier  Would be the States of the Signature of the Signatur	U.	29c. License number O.C.M.E.		29d Date signed (Month, Day, Year) September 4, 2006
05	30. Name and address of person who completed cause of comparita Korell MD. Assistant Medical		enn Street, Baltimore	, MD 21201	
25 State Registrar	9	ar's Signature			

06-06760 James McCarthy

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1 	Registrar				Death		Reg. N		<u> 2006</u>	
Physiciar lical Examin		1. Decedent's Name (First, Midd James David M					2. Da Mo Sei	ite of Death onth Da ptember 8	y . 2006 <sup>Y∈</sup>		ime of Death 1910 hrs
		4a. Facility Name (if not institution	on, give street and numb	ber)	4	b. City, Town, or Location		ptorriber 5	4c County		
		660 Americana Drive  5 Social Security Number		. Age (In yrs. last	hidhdau\	Annapolis  If Under 1 Year If Under	- 24U IO D	ate of Birth (N	Anne A		ce (State or
Funeral Director		226-96-0074	6 Sex 7.	43	Yrs.	Months Days Hours	Min	$\mathbf{v}$ . $4$		Foreign	France
v any	ı	Usual Residence of Decedent  10a. State  10b. County		10c. City, To	wn or Location					- 1	Inside City Limits
rland -f shov	ē	Maryland Anne	Arundel			Annapolis		140-	21		X Yes 2 No
	<u>a</u>	660 Americana	Drive, Apt	. 11		10f Zip Code 21403		109		What Country?	
leath with t r items 23a nust be not	Funeral	11 Marital Status 1 XXNever Married 2 M		dent Ever in US ces? 2XX No		s Decedent of Hispanic Ori es, specify Cuban, Mexican				ce - American I lite, etc	ndian, Black,
after d	g F		vorced If Yes, Give Year or Dates			Yes 2 X No specify:			Specify.		
2 hours af "natural		15 Decedent's Education (Spe-				t's Usual Occupation (Give ost of working life DO NOT		one 16	Kind of B	Business/Indus	try
thin 72 re than than edical	Completed	Elementary/occorridary (o 12)	3	0, 0.7	Polit	ical Surveyo	r		E	Politic	s
filed within 72 hour Hygiene dother than "nate the Medical Exar		17. Father's Name (First, Middle					r's Name (First,			ne)	
ev de de	Be l	David McCarth: 19a. Informant's Name/Relations	4		19h Mailing	Address (Street and Nur	llen Gr			num State 7in	Code) 24 402
TOTE, MID Z 12 13-0030 gaes 1 and 2 should be filed within 7 nt of Health and Mental Hygiens in 1. If them 27 is marked other than other transmatic event, the Medica		Ellen McCarth	y/mother	12	660	Americana Dr	ive, Ap	ot. 11,	Anna	apolis,	MD
s Lar S Lar of Hez If ite		20a. Method of Disposition  1 Burial 2 Cremation	n 3 Removal from		ce of Disposi matory or oth	tion (Name of cemetery, ner place)	Date	20	c Location	n - City or Towr	n, State
Dallimore, permit. Pages I ar Department of Her Important: If ite		4 Donation 5 Other S	pecify		Linco	ln Crematory	9/13/	′2006 E	3rentw	wood, M	aryland
Dalullio permit. Page Department of Important: injury or oth		21. Signature of Fulleral Service	License		22. N	ame and Address of Facilit	y John M	1. Tayl	or Fu	neral :	Home
	- 1	1 6 13-6			1 1 7	/ Dave of Gr	Ouces te	T 100.	LTI II TO	CTTOP	LID 7140
hysician	$\dashv$	23a. Part I. Enter the disease, o		sed the death. Do				ratory arrest,		neart Ap	
/Medical		23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease	e on each line	sed the death. Do	o not enter th			ratory arrest,		neart Ap	
/Medical		failure. List only one cause	e on each line a. Cardiac  Due to (or as a co	arrhythmia	o not enter th	e mode of dying, such as o	cardiac or respi			neart Ap	etween Onset and
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	e on each line  a. Cardiac  Due to (or as a co  b. Dilated  Due to (or as a co	arrhythmia onsequence of). cardioneya	o not enter th		cardiac or respi			neart Ap	etween Onset and
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	/Medi Examir		4a. Facility Name (If not institution, give			b. City, Town, or	r Location of Death	1	4c. County of		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "natural", or Items 23a or 28a-4 ehov any injury or other traumatic event, the Madical Examinar must be notified at ances.		21. Signature of Funeral Service Licen	see		lame and Addres		Funeral !	Hame		Tervis search
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State of Maryland / Department of Health and Mental Hygiene 2 006 For State Registra 29753 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Alene Elton MAY SEPTEMBER 6,2006 12:55A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 3,1926 Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 X F 80 215-20-9828 Mary land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentat Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iteme 23a or 28a-f ehow ner rust be notified at 1 Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 417 S. Burhans Blvd. East 21740 IISA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 0 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home O ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Franklin Hofe Ada Louise Sipes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 417 S. Burhans Blvd., East, Hagerstown, Md. 21740 John M. May - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: if any injury or once. Rest Haven Cemetery 4 □ Donation 5 □ Other (Specify) 9/9/06 Hagerstown, Maryland 21. Signature of Funeral Service Licens Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 8 has been signed 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ACUTE ON CHRONIC RENAL FAILURE Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? órmed? 20**X** No 2 No certificate 1 ☐ Yes 1 Yes or Attending Physician: After this certification, 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation М Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 6 66 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03H-4 BOON P.LIM M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Ma	ırylan	id / Depa <i>Cer</i>	artmer <i>tificat</i>	nt of H te of L	ealth a Death	and Me		gien <b>© (</b> Nog. No.	006	29754
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機。	Funeral Director		. 199-32-3717	ox / /. Age	(In yrs. 65	Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 03/24/	1941	9. Birthp	place (State or Foreign htry) PA
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	or 28a-1	Direct	10e. Street and Number					p Code				10g. Citizen	of What Cour	
	th v	a	1421 CHURCH HILL	ROAD				21617	7			US	SA	
9600	perr. it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f ehow appringly or other traumatic event, the Medical Examinar must be notified at ance.	d by Funeral Director	11. Marital Slatus 1 □ Never Married 2 → Marned 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ever in U	1	I ☐ Yes	2 No	Specify:	gin? (Spec , Puerto F	ify Yes or No- lican, etc.)	Spe		etc. HTE
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Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	Lel	Re	~ \frac{22}{E}	. Name ar LLOWS O SPI	nd Addres S. HE EER R	s of Facility LFENE OAD	SEIN CHES	AND NEW	NAM F	UNERAL 21620	HOME, PA
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Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ry - At ho	ome, farm, stre	et, factor	y, office		28	Bf. Location (Si City or Town	treet and Nu n, State)	mber or Rura	l Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medicai	29a. Certifying Ph (Check only one)	/sician: To the best of iner: On the basis of and manner state	examina	wledge, death tion and/or inv	occurred	at the tim	e, date and inion, deat	d place, ar h occurred	nd due to the cand at the time, d	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
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			1 - State Registrar	State of Ma	aryland / De	eparim Certific	ent of Hea	ath		Reg. No	2006	
	Physici /Medio		1. Decedent's Name (First, Middle, June C. M						2. Date of De. Month Aug.	31 Da	2006	3. Time of Death  1:49 P M
	Examin		4a. Facility Name (If not institution, 303 139th St.	give street and number)			City, Town, or Loc Cean City			40	County of Deat Worceste	r er
	Funeral Director		217-34-1265	6. Sex 7. Ago 1 ☐ M 2 🛣 F	67 Yı	Mon	nder 1 Year If U	Jnder 24 Hrs. ours Min.	8. Date of Bird (Month, Da Feb 12,	y, Year,	)   Co	nplace (State or Foreign unity) 71and
	Maryland -f ehow	tor	Usuel Residence of Decedent	ter	10c. City, Town	or Location						10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland me 23a or 28e-f ehow count be cotified at	al Director	10e. Street and Number 303 139th Street			101	. Zip Code 21842			U	itizen of What Co	untry?
0000	irs after dea	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 【XWidowed 4 ☐ Divorced	12. Was Decedent   Armed Forces?  1 Yes 200 If Yes, Give Year or Dates:			ecedent of Hispar specify Cuban, M as 2 X No Sp		ecity Yes or No Rican, etc.)	-	14. Race - Ame Black, White Specify: White	e, etc.
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Mary	2 shou and M is mar	18	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. N	Mailing Ado	iress (Street and I	Number or Run	al Route Numbe	er, City	or Town, State, 2	Tip Code)
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Банттог	permit. P Depertme Importar eny injur		21. Signature of Funeral Service L		, o. c. o. r	22. Nam Franc	e and Address of Cis J. Coll	Facility Lins Fune	eral Home,	, Inc	· ·	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. A.L.	the death. Do note.	t enter the	mode of dying, su	och as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
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	/Medic	al	Harry D. Mille:			4b. City. Town, o	r Location of Death			
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	land ow	1	Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Town	or Location				10d. Inside City Limits
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	or 28	Jirec	10e. Street and Number			10f. Zip Code		10g. C	tizen of What Co	untry?
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Maryland 21215-0036	2 hou	Completed by	15. Decedent's E	ducation	16a. I	Decedent's Usual Occup	pation	16b. F	Kind of Business/	
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Z	should nd Me mark imath	은	19a. Informant's Name/Relationship (		19b.	Mailing Address (Street				Zip Code)
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ore,	of He of He rothe		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 △		20b. Place of cemetery	Disposition (Name of crematory or other pla	ce) Da	te 20c. L	ocation - City or	Town, State
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	8		30. Name and address of person who		th (Item 23a) (		SON. MAR	YLAND	, 1	
	Sta	ite.	31. Date filed (Month, Day, Year)		- 477		vacur 15 - 1117115	1 500 11 7 50		
	Regist		SEP 1 8 2006	32. Registrar	15. 19	MATA				

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	/Medio Examir		4a. Facility Name (If no	ot institution, giv				4b. City, Town, o	or Location of Death			tc. County of Dea		7 102
		5.	HOLY CR	OSS HOS	PITAL				SPRING			MONTGOME	RY	
	Funeral Director		5. Social Security Num  NONE  Usual Residence of December 19 Decem	1	ex 7. A	ge (In yrs. last bii 52	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D AUGUST			country)	(State or Foreign YAOUNDE ON WA
	yland Now			0b. County		10c. City, Tow	n or Lo	cation					10d. lr	nside City Limits
	a-fe	ctor	MD	MONTGOM	ERY	SILVER	S	PRING					1)	X Yes 2 □ No
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	eath v	Funeral Director	3325 T. GA	RDEN CI	RCLE # 404		12 1	20904	disposio Origin? (Cr	posify Vec es N		MEROON 14. Race - Am	orican In	dian
Maryland 21215-0036	uges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heelih and Mental Hygiene.  If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other treumatic event, the Medical Examinat matter manife and or other treumatic event, the Medical Examinations.	þ	1 Never Married		Armed Forces  1 ☐ Yes 2 ☒  If Yes, Give Year or Dates:	?		f Yes, specify Cuba	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	0.	Black, Wh	ACK	orari,
5-0	72 hc	Completed	(Specify	5. Decedent's Ed	ducation de completed)	16a	(Give	dent's Usual Occup	during most of work	king	16b.	Kind of Business		1
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lan	uld be Aental rked o	To Be	BONJO BONJ	AWO JOS	ЕРН				MAKOUNGA	RACHEL	LE			
lary	2 should and Men is marke		19a. Informant's Nam					_	and Number or Rui					•
Σ,	1 and 2 Heelth tem 27		ATISTIDE		U/MOTHER				N CIRCLE					
Baltimore,	t. Partmer		20a. Method of Dispos  † XBurial 2 1 6  4 Donation 5  21. Signature of Fune	Cremation 3   ☐ Other (Specif		comota	ry, crer Y P		ce)	/2006	YA	OUNDE CA	AMERO	OON WA
Ba	Depermination of the permits of the		J N	W _	-10/6				DOVER ROA					оме 20785
			23a. Part1. Enter the shock, or heart f Immediate Cause (Fir	allure. List only	one cause on each I	ine.	not ent	er the mode of dyir				, i i i i i i i i i i i i i i i i i i i	Appi	roximate val Between et and Death
	Pnysician /Medical		disease or condition resulting in death)	-	a	E PANCYTO		NA					-	
В	Examiner		Conventially list condi	itions				DIFICIENC	CY SYNDRO	ME				
	sit ad	Iner	Sequentially list condi if any, leading to immi- cause. Enter Underly Cause (Disease or inju-	ediate ing	Due to (or as	a consequence	of):							
	and and I-trans	Examiner	that initiated events resulting in death) Las	_	c. Due to (or as	a consequence	of):							
68760,	sician buria			l	d	,	- 7-							
.89	tificate be executed g physician and as the burial-transit	edical			d									
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent print the past 12 months and 1 Yes 2 No. 9 Unknown	onths?		of pregnancy 2   Fetal death It time of death		Ectopic pregnancy Other (specify)	<i>'</i>			23d. Date of de Month	Day	Year
	w requires that been signed b should be deta		Part II. Other significa	ant conditions o	ontributing to death t	out not resulting in	n the ur	nderlying cause giv	ren in Part I.			use contribute t		
Vital Records,	The law resete has be page 2 she	Completed								24a. Was auto perf 1 Yes		death?	utopsy fir completi	ndings available on of cause of
Vita Vita	Physician: this certific ral director,	Be	25. Was case referred examiner?		Hospital:			Oth	26. Place of Deat					
	Phys r this ral dir	<u>۲</u>	1 Yes 2 No.	)	1 X Inpati		tpatien		4   Nursing no	ome 5 Res		6 □Other (Spe	ecify)	
O	Attending r death. ector: After by the fune	ıtlor	1 XNatural 2 Accident	5 Pending investigation	28a. Date of Inju (Month, Da	ay Year)	njury	Wor	k? Yes 2 □ No	200. 00001100	now my	ary occurred		
Division of	Hospital or Attendin 14 hours after death. Funeral Director: After fur fulled in by the fur	Certification;	_	6 Could not be determined	288. Place of in	jury - At home, fa tc. (Specify)	ırm, str	eet, factory, office		28f. Location City or To	(Street a	and Number or A	lural Rou	te Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha complately filled in by the funeral director, page	edical	one)	Madical Exam	ysician: To the best ninar: On the basis of and manner st	of examin <i>a</i> tion an	e, death	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	cause( , date a	s) and manner a nd place, and du	s stated. e to the c	ause(s)
	To the To the complet	Σ	29b. Signature and titl	of decition	Tayou	8 mD		29c. Licens DR635				SUST 29	th, Day, 1	
	(3)		30. Name and address						THE COST	NG 344	377	ID 00015		
	Sta	te	MARIA J.  31. Date filed (Month,	Day, Year)	ביים. Regist	rar's Signature	LEN	KUAD SII	LVEK SPRI	NG, MAR	YLAI	20910 עא		
DU	Registr		SEP	0 6 200	6 Clarent	rar's Signature	gne							

			1 - For State Registrar	State of M	Marylan	id / Depa <i>Cer</i>	artme rtifica	nt of H <i>te of L</i>	ealth a Death	and M	lental Hyg	iene 2	006	29759
			1. Decedent's Name (First, Middle, Last)								2. Date of Deal	th Day	Year	3. Time of Death
	Physicia /Medic	_	Andrew Ellicott Neall	ey							August 3	L, 2006		7:40 A M
	Examin		4a. Facility Name (If not institution, give s	street and number	er)		4b. City	, Town, or	Location	of Death		4c. Cou	nty of Death	
			9206 Mintwood Street			t think to 1		er Spr		24 Hrs	O Data of Birth		tgomery	lana (Chata an Francis
	Funeral		5. Social Security Number 6. Sex	M 2□F	Age (In yrs.	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day) Jan. 14,	Year)	Cou	place (State or Foreign htry)
	Director		220-53-9553 Usual Residence of Decedent		/		L				JdI1. 14,	1999	DC	
	low #		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits
:	Mar.	tor	MD Montgomery		s	ilver Sp	oring							1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Z	ip Code			1	0g. Citizen	of What Cou	ntry?
	23a (		9206 Mintwood Street				20	901				USA		
	eep .	Funerai		12. Was Decede Armed Force	s?	.S. 13. V	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Or n, Mexicai	igin? (Spo n, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
2	orit	<b>by</b> Ft	1. Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2	_		1 🗆 Yes	2 🔀 No	Specify:	•		Spe	cify: Whi	te
5	hour tural	ed b	15. Decedent's Edu	Year or Date	S.	16a. Dece	dent's Us	ual Occupa	ation			16b. Kind of	Business/In	dustry
2	in 72	Completed	(Specify only highest grade	completed)	-6 \	(Give	kind of w	vork done d use retired	luring mos	st of work	ing			,
7	the start	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Studen	nt					Never V	worked	
2	Hyg othe	Bec	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	e (First, Middle,			
0	Henta Henta	To B	Eric William Nealley						Sara	ah Eli	licott Sil	lver		
ם ک	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. "natural", or items 23a or 28a-f show is marked other then "natural", or items 23a or 28a-f show raumatic event, the Macinal Examinat must be notilized at		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Addre	ss (Street a	and Numb	er or Run	al Route Number	, City or Tov	vn, State, Zij	Code)
2	end 2 palth n 27 i		Eric William Nealley	/ father					reet,		r Spring,			
ט כ	# # # # # # # # # # # # # # # # # # #		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ F	emoval from Sta	0	Place of Dispo cemetery, crer	matory of	other plac	θ)		nber 6		on - City or T	own, State
			4 □Donation 5 □ Other (Specify)	amova nom ote	Dt.	Mary's			i	2006		Abingdo	on, MD	
5	pernit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylai Department of Health and Mental Hygiens. Department of Health and Mental Hygiens in natural, or items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens	9 <del>e</del>		22 H	Name	and Addres	s of Facili	ity S Fune	eral Home,	Inc.		
•	20559		y. New Stiles			5	500 Ur	niversi	ty Bl	vd. W	est, Silve	er Sprin	ng, MD	
			23a. Fart1. Enter the disease, or compl shock, or heart failure. List only or	cations that cause ne cause on each	sed the deat h line.	th. Do not ent	ter the m	ode of dyin	g, such as	cardiac (	or respiratory arr	est,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Increase	ed Intr	acranial	Pres	sure						10 days
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):								
		_	Sequentially list conditions,	Progress	sive Gl		oma Mu	ultifor	me				-	5 weeks
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that distance in the conditions of the condition	540 15 (51	40 4 0011000	400.100 017.								
	axecu and el-tra	xar	that initiated events resulting in death) Last	Due to (or	as a consec	quence of):								
000	cate be executed physicien and s the buriel-transit	dical E												
00	death certificate be executed e attending physicien and nd for use as the buriel-transit	edic										-1	1.	
Š	n cert andine use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom			Testonio	pregnancy					Date of deliv	*
0	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnan	t at time of c		Other (						Month	Day Year
5	at the by th tache	hys	9 Unknown				1/4				1			
ກົ	w requires that the death certific been signed by the attending p should be detached for use as	by	Part II. Other significant conditions co.	ntributing to deat	h but not res	sulting in the u	inderlying	cause give	en in Part	1,	1			the cause of death?
D CO	equir sen si ould	ted									1 1 4	es 2LAN	3 <u>1</u> Pro	bably 4 □Unknown
<b>S</b>	law r as be	ompieted									24a. Was a autop:	an 24	b. Were auto prior to co	opsy findings available empletion of cause of
	hysician: The law his certificate has b I director, page 2 s	Con									perfor 1 ☐ Yes		death?	2□ No
VII	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	to an ital.				104		e of Deat	h Check only or	ne/		
5	Physi this c	၉	1 Tes 24 No	fospital: 1   Inp		ER/Outpatier			4 ( IN	ursing Ho	me 5 X Resid			fy)
	ding F h. After funer	ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time o Injury	M	28c. Injun Wor	yaτ k? Yes 2.⊑	INO	280. Describe n	ow injury oc	curred	
DIVISION	Attending For death.	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e Place of	Initioy - At h	nome, farm, st			163 2	-	28f. Location /S	treet and Nu	mber or Rur	al Route Number,
₹	0 # 5 E	ertif	4 Homicide determined	building	etc. (Speci	ify)	ieet, iact	ory, ornos			City or Tow			a. · · · · · · · · · · · · · · · · · · ·
_	urs ere	C	29a. Certifier 1 X Certifying Phy	sician: To the be	est of my kn	owledge, deat	th occurre	ed at the tin	ne, date a	nd place.	and due to the d	ause(s) and	manner as	stated.
	To the Hos within 24 ho To the Func completely f	edical	(Check only 2 Medical Exami		s of examina									
	To the	Me	29b. Signature and title of certifier	_			2	9c. Licens	e number		2	29d. Date sig	gned (Month,	Day, Year)
	1		12-20	Pms			I	55584	Ŀ		5	eptembe	er 1, 20	006
	•		30. Name and address of person who c		of death (Ite	m 23a) (Type,	, Print)							
			Brian Rood, M.D., 1	11 Michig	an Aven	ue NW, V	Vashir	ngtan,	DC 20	010		- 44		
	Sta Regist	ate	31. Date filed (Month, Day, Year) SEP 0.5.20	- 100	jistrar's Sign	ature A	200	,						
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DHMH 17 Rev 1/2001

ORIGINAL

Amend item# PII,25,pen/E,880, 10/12/06 TT State of Maryland / Department of Health and Mental Hygiene 2005 1- State Registrar Amend#20b.20c.PerFH PCC 9-13-06cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 08/31/2006 **Physician** 10:08 am Frances T. Pennoh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/05/1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sax **Funeral** Months Days Min. Hours 1 M 2 F 214-43-8954 96 Director Liberia Usuat Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Montgomery Silver Spring Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 Ie markad other than "neturel", or Iteme 23a or: 10100 New Hampshire Ave #T1 20903 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned ☐Yes 2XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black t Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Private Home Maker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Taba Pennoh Mary Pennoh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James W.Garnett/Grandson 2321 Calliope Way #201, RaLEIGH, NC 27616 20b. Place of Disposition (Name of cemetary, crematory or other place)
All Souls Cemetery 20c. Location - City or Town, State Silver Spring, MD Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department Important: If any injury or once. Mis Cemetery 9/16/06 Sermantown, M 22. Name and Address of Facility Taylor's Funeral Home 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 1722 N.Capitol St.NW Washington, DC 20002 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Urosepsis **Physician** 12 hours disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed PPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by cate has been sign, page 2 should be Quadriparesis secondary to cervical stenosis 1 ☐ Yes 2 ☐ Kio 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 € No 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 12 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1X Naturat 5 Pending death. 1 🗀 Yes 2 🗆 No investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Intury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 2 To the I 29b. Signature and title ocertifia 29d. Date signed (Month, Day, Year) 29c. License number 63168 09/01/2006 30. Name and agrees of person who completed cause of death (Item 23a) (Type, Print) Shyam Parkhie MD 18101 Prince Phyllip Dr. Olney, MD 31. Date filed (Month, 32. Registrar's Signature State SEP 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 For State Ragistrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** George Priddie 7:00 A. M Leotha August 31, 2006 /Medical 4a. Facility Name (If not institution, give street and number)
Heartland Health Care Center
of Hyattsville 4c. County of Death 4b. City. Town, or Location of Death Examiner Hyattsville Prince Georges 7. Age (In yrs. last birthday)
O1 Yrs.

O1 Yrs.

O1 Yrs.

O1 Yrs.

O2 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year)
O3 West
Country) West
Trinidad, Indies 5. Social Security Number 6. Sex **Funeral** 1 □ M 2**X**) F 021-66-6923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show or other traumatic event, the Nedical Examination notified at 1▼ Yes 2 No Directo Hyattsville Prince Georges Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 238 6500 Riggs Road 20783 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status o filed within 72 hours after d I Hygiene. other than "natural", or Itam 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nursing Homes 8th grade **Nursing Assistant** other 1 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Charles .Tamie George Dingwall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Avalon Ayeba George(Grand daughter) 2807 - 26th Street, N.E.; Washington, D.C. 20018 Sept. 11, 2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Beltsville, Maryland A □ Donation 5 □ Other (Specify) Chesapeake Crematory, Inc. 21. Signature of Funeral price Licensee Name and Address of Facility
R. N. Horton Company Morticians, Inc. Dandspin 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PERIPHERAL VASCULAR DISEASE Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate ba executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 🗶 No ed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Onknown 17 DERJENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2**X** No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b Time of 27. Manner of Death 28d. Describe how injury occurred al or Attending P s after death. Il Director: After After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 🗌 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) Hospital 24 hours a 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 5th, 2006 D0058290 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Muttath, M.D.; 4203 Queensbury Road; Hyattsville, Maryland 31. Date filed (Month, Day, Year) SEP 0 6 2006 State Registrar

			1 - State Registrar  1. Decedent's Name (First, Middle, Last)	State of Marylar	nd / Depa	artment o	of Health and of Death		Reg. No.	006	29762
	Physici /Medio Examir	al	LEROY PAYN  4a. Facility Name (If not institution, give st			4b. City, To	vn, or Location of Dea	Month 6 S	Day 31	Year 2006 inty of Death	0410 M
	Funeral Director		5. Social Security Number 726–10–6564 1 TX	LAND HOSP  M 2DF  7. Age (in yrs. 75	ITAL last birthday) Yrs.	If Under 1 Y	ear If Under 24 Hr. ays Hours Min			9. Birthp Count	place (State or Foreign
	he Maryland 18s-f show otified st	ector	10a. State 10b. County  Maryland Prince Ge		ty,Town or Lo	l1e			10 000		0d. Inside City Limits  1
	3a or		3719 Donnell Drive	#304		10f. Zip Co	2074	8	United	of What Cour State	-
9036	72 hours after death with the Maryland "neturel", or Iteme 23a or 28e-f show idical Examinational be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates: 1961	L-	Was Deceden If Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No rto Rican, etc.)		Race - Americ Black, White, Broify: <b>Blac</b>	etc.
21215-0036	within ane. then "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation	16a. Dece (Give life.	DO NOT use r	lone during most of wo	orking	Fort	Myer's	3
Maryland 2	be filed stal Hyg od other event,	To Be Co	17. Father's Name (First, Middle, Last) Unknown		CONSC			me (First, Middle, Payne			
Man	12 sho h and 7 is m ireum		19a. Informant's Name/Relationship (Type Victoria M. Rineha	•			reet and Number or F				Code)
Baltimore,	permit. Pages 1 end Department of Healt Important: If Itam 2' any Injury or other 1	I i	20a. Method of Disposition  1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Fineral Service Licenses	moval from State	antico		al Sept	bert G.	Triang Mason	Funera	rginia 1 Home Inc
8760,	Physician / Medical Examiner publication and physician it provides the private provides the private provides the private private provides the private	Ical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one timmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Due to for as a consect	quence of):  AV	er the mode o	oying, such as carola	ac or respiratory a	rrest,		Approximate finterval Between Onset and Death
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	al death 3	Ectopic pregr Other (specia				Date of delive	ory Day Year
	w requires that been signed b should be deta	þ	Part II. Dther significant conditions cont	ributing to death but not res		1	e given in Part I. HUGE KLMU	1	obacco use c		ne cause of death? ably 4 Winknown
Division of Vital Records,	: The law requirate has been page 2 should	Completed	disecuse, hece	it failur	<u>d</u>		V	24a. Was autop pento 1 ☐ Yes	an 24 osy rmed? 2\(\infty\)No	prior to cor death?	psy findings available inpletion of cause of 2000 No.
Vita	sician: Th certificate irector, pag	) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital:	150/0		Other	eath (Check only o			
ion of	Jing After	atlon: To	27. Manner of Death  1 Natural  2 Accident investigation	ospital: 1 ≼ Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?  1 Yes 2 No	Home 5 Resi			/)
Divis	를 를 들	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, of	fice	28f. Location (. City or To		mber or Rura	l Route Number.
	Hospital 24 hours Funarat tely filled	Medical	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	cien: To the best of my knows: On the basis of examina	owledge, deat ation and/or in	h occurred at t vestigation, in	he time, date and place my opinion, death occ	e, and due to the curred at the time,	cause(s) and date and plac	manner as st	tated. the cause(s)
	To the vithin : To the comple	Mec	29b. Signature and title of certifier	whou, M	D	The state of the s	cense number		29d. Date sig	3   2	
_	(5)		30. Name and address of person who con VARSHA VANIKAR	. SOUTHERN M	TARYLAN		TAL, 7503	SURATTS A	OAD, C	LINTO	v md -20735
	Sta Regist		SFP 0 7 2006	32. Registrar's Sign	Local	W.					

		1	For State Registrar	State of Marylan			of Health and I	Mental	Hygien	2000	29763
/M	sicia edica imine	n il	1. Decedent's Name (First, Middle, Last  2. A. Facility Name (If not institution, give	Proctor	Jr	4b. City, To	own, or Location of Deat	Sept	t. 1,	ay Year 2006 c. County of Dea	3. Time of Death 1:58 A M
Fune Direc			Civista Medical Co. Social Security Number 213-72-2772	Center 7, Age (In yrs.	last birthday) Yrs.	Months I	Near of Hunder 24 Hrs. Days Hours Min.	8. Date	(//, Duy, / Ou	11	thplace (State or Foreign ountry)
death with the Maryland ms 23a or 28a-f show	TO THE PARTY.		10a. State 10b. County  Maryland Charles  10e. Street and Number	10c. Cit	y, Town or Lo	cation  10f. Zip C	Hall		10g C	itizen of What C	10d. Inside City Limits 1 Tes 2 No
ter death with	NA TRANSPORT	Funeral Director	7564 Newinan  11. Marital Status  1 × Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{N} \) No	S. 13. \		206 22 nt of Hispanic Origin? (S y Cuban, Mexican, Puen	pecify Yes to Rican, et		USA 14. Race - Am Black, Whi	erican Indian,
within 72 hours after ene.	ESTERNIE LANG	Completed by F	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates:  ucation le completed)	16a. Deced	dent's Usual ( kind of work DO NOT use	Occupation	rking	16b.	Specify:	Vindustry
be filed htal Hygi	C event, It e	Be	17. Father's Name (First, Middle, Last)	College (1-4or 5+)	2. 4	ntena		-	Ch, Middle, Maide	n Surname)	of Guv't
S, WICHTY IS and 2 should lealth and Mer	Language	<u>o</u>	19a. Informant's Name/Relationship (T) Frances E. Junes	pe, Print) MoHer	19b. Mailin	ng Address (S	Street and Number or Ru		11 1/	or Town, State,	Zip Code)
Pages 1 at nent of Hea	ry or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Place of Dispo emetery, cren	sition (Name natory or oth	of er place) Con 9/6	Date	-	Location · Sity or	Town, State
Daltimo	ony inju		21. Signature of Fundial Service Licens		91 /	Name and	Address of Facility Funcial	Hom	e 1A	Aunso	MD ZOLSE
Physic			23a. Part 1. Enter the disease, or communication of the control of	ications that caused the deatled cause on each fine.	h. Do not ent	er the mode	of dying, such as cardiad	c or respira	tory arrest,	0	Approximate Interval Between Onset and Death
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The la	or, page 2 sr	e Completed	25. Was case referred to medical				26. Place of Dea	10	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
g Physician: genthis certific	eral direct	0 0	examiner? 1 Yes 2 No 27. Manper of Death	Hospital: Anpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other	lome 5			ecify)
or Attending ter death. irector: After	n by the rur	ertification:	Natural 5 Pending investigation  Suicide 6 Could not be determined	28e. Place of Injury · At he building, etc. (Specification)	ome, farm, str	М	1 Yes 2 No		ation (Street a or Town, Sta		lural Route Number,
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Alternation	etery rilled	edical Ce	29a. Certifier 10 Certifying Phy (Check only one) 1 Medical Exem	rsician: To the best of my kno iner: On the pass of examina and marther stated.	wledge, death	n occurred at vestigation, in	the time, date and place	e, and due urred at the	to the cause( time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
To the within To the	compie	₩ We	29b. Signature and title of certifier		w	29c. l	License number		29d. D	ate signed (Mon	th, Day, Year)
B5			30. Name and address of person who de B. Larry Jenkins,	Jr., MD, 111	LaGran	nge Ave		2665,	LaP1a	ta, MD 2	20646
Red	Stat gistra		31. Date filed (Month, Day, Year) SEP 0 6	32. Relistrar's Signa	iture	book					

		For State Registrar	State of Marylar		artment of F			giene 20 (	06 29764
Physicia		Decedent's Name (First, Middle, La     Paul Frankl					2. Date of Dea Month September	Day Yes	
/Medica Examine		4a. Facility Name (If not institution, given Washington Coun	ve street and number)			r Location of Dea gerstown	th	4c. County of D Washin	
Funeral Director		213-18-8949	Sex 7. Age ( <i>ln yrs.</i>	last birthday)	If Under 1 Year Months Days	ff Under 24 Hrs Hours Min		y, Year) 1921	Birthplace (State or Foreign Country) Maryland
faryland ebow	or	Usual Residence of Decadent  10a. State 10b. County  Maryland Wash	ington 10c. Ci	ity, Town or Lo	rstown			<u> </u>	10d. Inside City Limits 1 ☐ Yes 2☐ No
with the his or 28e-file	Director	10e. Street and Number	ve.		10f. Zip Code	21740		10g. Citizen of What	
0 0 0	by Funerai	11. Maritat Status  1 Never Married 2 Married 3 Xidowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? M☐Yes 2☐No If Yes, Give	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. White
thin 72 hours 6. an "natural", Medical Exp	Completed b	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Year or Dates: iducation ade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of Busine	
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nd 2 should be the and Mental 27 le marked of traumatic eve	٩	William Pottorf  19a. Informant's Name/Relationship  Larry W. Pottor	(Type, Print)			and Number or R		raf or, City or Town, Stat own Maryla	
Pages 1 and nent of Health int: If item 27 ary or other tr	3)	20a. Method of Disposition  1    Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Special Content of the Conte	Removal from State	Place of Dispo	osition (Name of matory or other place wn Memor	ce)	Date	20c. Location - City	
pernit. Deportm Importa any nju		21. Signature of Funeral Service Lice	A Frency						neral Home ryland 21742
Physician /Medical		23a: Part1. Enter the isease, or conshock, or heart filter. List only immediate Cause (Final disease or condition resulting in death)	nplications that a used the deal one cause and line.  a.  Due to (or as a conse	can	ter the mode of dyir	ng, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for as a sursec	ionia					-603
	cal Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consec	quence of):					
eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of Month	delivery Day Year
es the	ò	Part II. Other significant conditions	contributing to death but not re	sulting in the (	underlying cause giv	en in Part I.			e to the cause of death?  Probably 4 □Unknown
vical necona sician: The law requin s certificate has been si irrector, page 2 should I	Completed						24a. Was autop perfor 1 🗆 Yes	sy prior rmed? death	a autopsy findings available to completion of cause of 1?
iclan: certific	Be	25. Was case referred to medical examiner?	Hospital:		nt 3C DOA Oth	000	eath (Check only o		
ng Phy Merthis	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c Injur	4 🗆 Nursing		dence 6 Other (S	Specify)
To the Hospitel or Attendiwithin 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determined		nome, farm, st	reet, factory, office		28f. Location (5 City or Ton		r Rural Route Number,
To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or in	ivestigation, in my o	ppinion, death occ	curred at the time, o	date and place, and	due to the cause(s)
To With To Con	Σ	29b. Signature and title of certifier			29c. Licens	2323		29d. Date signed (M	onth, Day, Year)
5H-4+1		30. Name and address of person who	1126 Op	al C	Print)	(tog.	ms .	21740	
Star Registra	-	31. Date fifed (Month, Day, Year) SEP 08	32. Registrar's Sign	S. A.	well	l			

06-06419 Please Type or Print in Black Indelible Ink Shawn Edward Powell State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 29765 Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ **EDWARD** POWELL SHAWN 0823 hrs Medical Examiner August 27, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 11241 A Crystal Run Columbia Howard If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Hours Davs Director Country) MD 1 X M Yrs Feb.5,1988 216-27-4237 2 18 Usual Residence of Decedent 10d Inside City Limits īn 10a. State 10b County 10c. City. Town or Location 1 X Yes 2 No 28a-f show once. Columbia Howard MD hours after death with the Maryland Director s 23a or 28a-f e notified at o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 12205 Little Patuxent Pkwy 21044 U.S.A. Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, or items must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married Yes 2 X No Black 1 Yes 2 X No specify: 3 Widowed 4 Divorced Specify: If Yes, Give Year traumatic event, the Medical Examiner "natural" 2 r Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene other than 12th Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Ray Mitchell Powell Patricia Diane Kelly Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0770 19a Informant's Name/Relationship (Type, Print) item 27 is 8527-B Greenbelt Rd #T-2 Greenbelt, Ray M. Powell Jr- Brother 20a Method of Disposition Rlace of Disposition (Name of cemetery 20c. Location - City or Town, State 3altimore, natory or other place) 1 X Bullrial 2 Cremation 3 Removal from State 9/5/06 Department o National Mem Laurel, MD Donation 5 Other Specify Signature of Funeral Service L 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 Approximate Interval Part I. Enter the disease. of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and failure. List only one cause each line /Medical Death Gunshot wound to back of chest Immediate Cause (Final diseas) Examiner or condition resulting in death) Due to (or as a consequence of Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and trans. Physician/Medical UNPENDED ling physician as the burial -AMENDED Box 68760. 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o à 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes ✓ Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Vital Be examiner? Other \_ Inpatient 2 DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? ō After Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject shot FOUND Division Natural 1 Yes 2 V No Pending after death. Director: Aug 27, 2006 0818 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 11241 A Crystal Run, Columbia, MD determined (Specify) Sidewalk 4 V Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

within 2

State

Registra

30 Name and address of person who completed cause of death (Item 23a)

2006

05

Assistant Medical Examiner

32 Registrar's Signat

Ana Rubio MD.

31. Date filed (Month, Day

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 28, 2006

State of Maryland / Department of Health and Mental Hygiene 2006 29766 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Aŭgust 28, 2006 Parker 3:20P.M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Clarksburg 10511 Rolling Green Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 13, 1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Massachusetts 1 ☐ M 2 💢 F 90 034-10-1692 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Perfect of Health and Mental Hygiene. Incorporate if I Item 27 Is marked other than "natural", or Itema 23a or 28a-f ehow employe or other treumatic event, II a Madical Examinar must be notified at once. Rockville 1 ☐ Yes 2 📉 No Maryland Montgomery Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 13906 Congress Drive 20853 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomashow Sadie Katz Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10511 Rolling Green Court Clarksburg, Maryland 20871 Howard Parker -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State King David Memorial Gardens 8/31/2006 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Far ral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 2 months 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastric Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Causa (Disease of Figury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 2X No 3 Probably 4 Unknown should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate hes t irector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other Spanings residence 1 Yes 2 No 3□ DOA Medical Certlflcation; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the f 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D24245 August 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan J. Diamond, M.D. 10801 Lockwood Drive, #200 Silver Spring, Maryland 20901 32 egistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

0 5 2006

Registrar

DHMH 17 Rev 1/2001

SEP 0 6 2006

State of Maryland / Department of Health and Mental Hygiene 2006 29768 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006 6:45 P M Sept. **Physician** Charles E. Robertson, III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | April 8, 1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months **Funeral** Maryland Yrs. 214-20-9387 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show !/ Is marked other then "neturel", or liems 23e or 28e-f shov treumatic event, the Modical Examinar must be notified at 1 \_**X**es 2 ☐ No Prince George's Bowie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 13028 Marquette Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 1 XYes 2 No If Yes, Give Year or Dates:WW II 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White 3 ☐ Widowed 4 M Divorced þ 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within in and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) AT&T Corp. 5+ Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louise Baker Charles E. Robertson, Jr. 19a. Informant's Name/Relationship (Type, Print). Former 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, MD. 13028 Marquette Lane Virginia Robertson f Health spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 09/08/2006 Alexandria, VA. permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service tsicense 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia ardiac Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Simus SICK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Cardin Vascular disease Atherosclenotic The law requires that the death certificate be executed tran resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Completed by Physician/Medical the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown Division of Vital Records, 1 ☐ Yes 2 ☐ No Fuilure 24b. Were autopsy findings available prior to completion of cause of death? Myeloproliferative disorder 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director, page 2 has 2□ No End Stage Dementic 2 1 No 1 ☐ Yes 1 Yes 26. Place of Death Check onl one Hospitel or Attending Physicien: Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Many of Death 28a. Date of Injury (Month, Day Year) 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined illed in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9-5-2006 D 50653 eyan.c -ova, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C SURANA Road Deale Deale State 2006 Registra

		-	State of Maryla  State Registrar	nd / Department of Health and N Certificate of Death			29769
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Frank Alfred Ross		2. Date of Death Month August	26 2006	3. Time of Death 0844aM
21215-0036 Hall	Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  Dorchester General Ho  5. Social Security Number  6. Sex  7. Age (In yrs  216-14-8175  104M 20 F  83	4b. City, Town, or Location of Death  Camb mo(9)  (last birthday)   If Under 1 Year   If Under 24 firs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	Dorches  9. Birthpl Count	ry)
121215-0036 Hall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Imprortent: If Item 27 is marked other then "natural, or Items 23s or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Dire	Maryland Derchester Ea  10e. Street and Number  4011 Railroad Avenue  11. Marital Status  1 Never Married 2 Married 3 Midowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Decedent Ever in Armed Forces?  12. Was Decedent Ever in Armed Forces?  15. Decedent's Education (Specify only highest grade completed)  College (1-4or 5+)  No Me	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  For Kiff Operator	2. Date of Death   Ab. City, Town, or Location of Death   August   Ab. City, Town, or Location   Ab. City, Town, or Location   Ab. City   Ab. City, Town, or Location   Ab. City		
.8760, Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be fill by the physicien end many in the burial-transit and many or other traumatic even page.	dical Examiner To Be	1 MBurial 2 □ Cremation 3 □ Removal from State  1 □ Onation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  1 □ Libert L. Burnulley  23a. Part1. Enter the disease, or complications at caused the deshock, or heart failure. List only one caus on each line.	19b. Mailing Address (Street and Number or Ru. 3600 Ko Hh Lime Rich. Place of Disposition (Name of cemetery, crematory or other place)  Stern Share Veterans Septem 22. Name and Address of Facility  Bearaley Funera  ath. Do not enter the mode of ring, such as cardiac  OSCLEROTIC HE  Equence of):	Date 20  About Signal Diving Date 20  About 5, Let 1  About 5 let 1  About 5 respiratory arrest	Johnson Dity or Town, State, Zip Linia 2322 C. Location · City or Town Lurlock	wn, Slate  Vland  Street  arviand 21613  Approximate Interval Between
Division of Vital Records, P.O. Box 68	r Attending Physician: The law requires that the death certif for death. Irector: After this certificate has been signed by the attending trector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use an	Certification; To Be Completed by Physician/Medi	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation (Month, Day Year)	asulting in the underlying cause given in Part I.  Description  26. Place of Dea  Per/Outpatient 3 DOA  Other: 4 Nursing H  Work?  M 1 Yes 2 No  home, farm, street, factory, office	1 Yes  24a. Was an autopsy performe 1 Yes 28  th (Check only one) ome 5 Residence 28d. Describe how	Month  cco use contribute to th  2 No 3 Probi  24b. Were autor prior to condeath? 1 Yes  ce 6 Other (Specify injury occurred	ce (State or Foreign  y and  1. Inside City Limits  1  Yes 2  No  y?  In Indian,  c.  C.  C.  C.  C.  C.  C.  C.  C.  C.
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			30. Name and address of person w	ho completed cause of	death (Item 23a	(Type, Print)	,-						`	
			Robert Coxer	P.O. 21	B Nest	2/ 5%.	3	a/Isbu	14,	Ms				
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	Funeral Director		5. Social Security Number  114-46-1044	6. Sex 1 M 2 □ F	7. Age (In yrs. <b>77</b>	Yrs.	Months Days	Hours Min.		Year) 1928	9. Birthpla Country Par	ce (State or Foreign y) nama
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200	nding th. : After e fune	tlon	1 Accident investi		of Injury th, Day Year)	Injury	28c. Injury : Work? M 1 \( \sup \cdot \)	es 2 No	20d. Describe no	w injury occurr	eu	
	To the Hoepitel or Attending Physicien: The law within 24 bours atterdeath.  To the Funeral Director Atter this certificate has gompletely illed in by the funeral director, page 2 to prompletely illed in by the funeral director, page 2 to prompletely illed in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 286. Place	of Injury - At ho ng, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Numb , State)	er or Rural F	Rou <i>te Number,</i>
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	12		- Teore	ne xul	pers	- 00-1/2				Augus	t 31,	, 2006
			30. Name and address of person Ghousia Sult					cir Si	lver Spr	ing,	MD 20	906
	Sta Registr		31. Date filed (Month, Day, Year)	5 2006 32. R	agistrar's Signa	iture	neadle 2					

State of Maryland / Department of Health and Mental Hygiene 2006 Amend Items For State Registrar 23a,25 perDr/ME,G859,09/12/96 blath 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 4:58 AM Rader SEPTEMBER 1 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 8. Date of Birth Apr 18, 1906 Birthplace (State or Foreign
 Oppring) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 100 Director 220-10-4919 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or itams 23a or 28a-f ahow the Madical Examinar must be notified at Cumberland Allegany MD 1 TXes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 728 Oldtown Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: white 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F Pages 1 and 2 should be Nannie (Bean) Yankev John Yankey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code)
434 Arch Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) of Health a Juanita Weisenmiller daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 Daurial 2 Cremation 3 Removal from State 9/4/2006 MD Department of important: If any injury or once. St. Mary's Cemetery Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nam Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Abdominal Immediate Cause (Final disease or condition resulting in death) exported 3 days **Physician** /Medical Due to (or as a consequence of): Examiner Probable Perforated Ulcer 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed nding physicien and use as the burial-tran Due to (or as a consequence of): hus MEDICAL EXAMINER Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 1 mpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred After t 5 Pending investigation 1, A vatural after death. 1 Yes 2 No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue Cumberland MD 21502 31. Date filed (Month, Day, Year) M.D. 32. Registrar's Signature State SEP 1 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200629773 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 1, 2006 **Physician** GOLDIE MARIE ROBINSON 7:57 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7009 Blacks Mill Road Thurmont Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 29, 1928 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary Land Months Days 1 ☐ M 2 💢 F 212-24-6435 77 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Ever traumatic event, the Medical Ever traumatics event. 1 ☐ Yes 2 🔯 No Director Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 7009 Blacks Mill Road 21788 U.S.A. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 should ba filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Ital 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Ketterman Cora Swisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 Is i ury or other traus Albert Robinson Jr. / Husband 7009 Blacks Mill Road, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Resthaven Mem. Gardens 9/5/06 ' 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Lensee ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A. 3 de 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Farction yocardia minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and had for use as the burial-transit law requires that the death certificate be executed I thero Sclevori Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 26. Risco of Death (Check only on 2 🗆 No crebro vascular discase 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica filled in by the funeral director. 25. Was case referred to medical examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A Husan MD

State Registrar DHMH 17 Rev 1/2001 Vaaz

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2006

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PREDERICK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NA R 2 1) HUSSAN 151

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06-06472 Timothy O. Stev	ens	on State	Please Type or e of Maryland / Depa		lack Indelible in			
		1- For State 27, 29d, 30 g	ner M.E. ho Ce	rtificate of L	nealm and Mema Death 8 / 31 / 06	-	200	16 2977
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Medical Exami		Timothy	O. STEVE	NSON		Month August 29,		0112 hrs
-		4a. Facility Name (if not institution, g		1	City, Town, or Location of	Death	4c. County of Deat	h
		Peninsula Regional Med  5. Social Security Number 6.	Sex 7. Age (in yrs.		Salisbury  If Under 1 Year   If Under	24Hrs 8 Date of Right	Wicomico	dholace (State or
Funeral Director			M 2 F	35 Yrs.	Months Days Hours	Min. 12-29	Forei	
		Usual Residence of Decedent	2 7	9J 118.	. 71	13-31	19 10   "	1 1
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rith the		30326 Bowland	12. Was Decedent Ever in U	IS 13 Was I	Decedent of Hispanic Origin	n? ( Specify Yes or No-	14 Race - Amer	rican Indian, Black,
r death wi or items?	Funeral	1 Never Married 2 Marrie			specify Cuban, Mexican, F		White, etc.	a a
after de	by Fi	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates:	1 🗀 Y	es 2 🔀 No specify:		Specify:	lack
hours natur Exami	eted k	15. Decedent's Education (Specify			Usual Occupation (Give kir of working life. DO NOT us	nd of work dane se retired)	16b. Kind of Business	of Maryland
36 nin 72 than "	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)	Foo	d SERVICE	-	Eastern ,	
5-0036 Iled within 7 Hygiene I other than	Comple	17. Father's Name (First, Middle, Las	st)	1 00		Name (First, Middle, M		OLIGITÉ
be filler Head	Be	GORDON B	ECKEL		Ca		TEVENSO	
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Z 5 da in Z in Z	201	Carlota STEV	coson - Mother 120b.	Place of Disposition	Bowland Con (Name of cemetery,	Date Date	20c. Location - City of	
of H		1 Surial 2 Cremation 3		crematory or other	1 0	09-02-06	Princess	1
Baltimo permit. Pag Department Important: injury or ot		4 Donation 5 Other Special 21. Signature of Funeral Service Lice		hn Wes	ne an Address of Facility		1.4	Anne MD
Balt permit. Departi Importi	1	Hultony E.	Wards	30	Hong E U	ALL FUNC	ess Anne M	h 21863
Physician		23 Part I. Enter the discase, or confailure. List only the cause on		n. Do not enter the		diac or respiratory arre-	st, shock, or heart	Approximate Interval Between Onset and
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e executed cian and nial - transit		events resulting in death) Last	d					
be exe ician a	cian/Medical	UNPENDED	AMENDED					
i, P.O. Box 68760, ires that the death certificate be signed by the attending physic be detached for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pred 1 Live birth		death 3 Ectopic p	pregnancy	23d. Date of deliver	•
x 68 h certi tending use as	iciar	past 12 months?	4 Pregnant at time of d	ooth -	death 3 Ectopic p (Specify)	regriancy	Month	Day Year
Bo re deat the at ted for	Physi	1 Yes 2 No 9 Unknow	9 Onknown					
P.O. es that the igned by be detach	by P	Part II. Other significant conditions	s contributing to death but not	resulting in the und	erlying cause given in Part	1 23e. Did tob	acco use contribute to	
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Division of Vital Records, tal or Attending Physician: The law requiring all preferences that the certificate has been siled in by the funeral director, page 2 should be		25. Was case referred to medical	· -		26 Place of Poeth (C	1 Yes 2	No 1 Y	es 2 No
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Divisior  Hospital or Attend 24 hours after death Funeral Director:	Cer	4 Homicide determine 29a Certifier 1 Certifying Physics	J (Openin) Single Fai			30326 Bowla	nd Court, Princes	
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Yuneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only Certifying Fifys	ician: To the best of my knowled er:On the basis of examination:					
To the within To the Comple	Med	29b. Signature and title of certifier/	and manner stated		29c. License number		29d. Date signed (Mo	onth, Day, Year)
		(and H	Alle -		O.C.M.E.		· August 2	29. 2006
		30. Name and address of person wh	o completed cause of death (Iter	m 23a)				,
		Assistant Medical Ex			MD 21201 Caro	l H. Allan,	MD	3
	tate	31. Date filed (Month, Day, Year)  AUG 3 1 2	32. Refistrar's Signal	ture	A.			
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			For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment rtificate	t of H e of L	ealth a	and M	ental Hyg	giene Reg. No.	2006	2977	5
	Physici /Medio	al	Decedent's Name (First, Middle     MARTHA  4a. Facility Name (If not institution)			OMAS	4b City	Tour or	Location o		2. Date of Dea Month SEPT	3 <sup>Day</sup>	2006 Year	3. Time of Death 9:10 A	И
-	Examir Funeral Director	ier	HEARTLAND NUR 5. Social Security Number 214-16-7847	SING HOME		last birthday) Yrs.	HYAT  If Under  Months	TSVI			8. Date of Birt (Month, Day FEB 1 4	PRI	NCE GEO	place (State or Foreig	חק
	70	ector	Usuel Residence of Decedent  10a. State  10b. County	E GEORGE'S		y, Town or Lo								10d. Inside City Limits X□ Yes 2 □ No	
36	permit. Pages 1 and 2 should be itled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-1 ahow any injury or other traumatic evant, I're Medical Evanting must be routified at ODGs.	y Funeral Director	4942 LAKELAND  11. Marital Status  1 □ Never Married 2 □ Marr  3 □ ₩idowed 4 □ Divorced	12. Was Deced	es? È∐ No			2074 lent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- lican, etc.)	. 14	J.S.A. Race - Ameri Black, White,	can Indian,	
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Maryland	should be fit and Mental H s marked ott umatic evan	To Be	17. Father's Name (First, Middle,  JOHN A. THOME  19a. Informant's Name/Relationsi	AS nip (Type, Print)					MARY	ELL]		AND I	ERSON Town, State, Zij		_
Baltimore, Ma	ages 1 and 2 ant of Health a it: if itam 27 ls y or othar tra		BARBARA PEOPLES  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)	3 □Removal from St	ate	4942 Place of Disposemetery, crer	sition (Nam natory or ol	ne of ther place	1-1	D	LEGE PA	20c. Loca	ARYLAND  ution - City or To  OVER, MA		
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760,	ate be executed hysician and hysician and the burial-transit	lical Examiner	23a. Part1. Enter the disease of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CAI Due to (or Due to (or	RDUI PI	ULMONAI juence of): ARDIOMY	RY ARI	REST		cardiae of	isspiratory at			Approximate Interval Between Onset and Death	
.O. Box 68	es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∏ Feta nt at time of d	ıldeath 3 [	Ectopic pro					23	d. Date of deliv Month	ery Day Year	
ords, P	The law requires that ste has been signed b age 2 should be deta		Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I.					he cause of death? bably 4 ZiUnknowr	n
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Division of Vi	ding Phys h. After this funeral di	ertification; To Be	examiner? 1 Yes 2 A No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	28a. Date of (Month, ation look 28e. Place of	Injury Day Year) I Injury - At he	ER/Outpatien 28b. Time of Injury	M 2	8c. Injury Work 1 🗀 \	00 40 Nu	rsing Hom 2 No	ne 5 Residence R	lence 6 [ ow injury of		fy) al Route Number,	
ā	Hospital or 4 hours afte Funaral Dir ely filled in I	edical Cert	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the b Exeminer: On the bas	is of examina	owledge, death						cause(s) ar			
)	To tha I within 2 To tha I complet	Med	29b. Signature and title of certifier  30. Name and address of person	~	1	n 23a) (Tvpe.		License	number	47	1	29d. Date :	signed (Month)	Day, Ygar)	
	Sta Regist		MASKEEN KAN 31. Date filed (Month, Day, Year) SEP 0 6 20	GO M.D. 76	10 CAR	ROLL A	VENUE	# 2	05 TA	KOMA	PARK,	MARY	LAND 20	912	

		State of Maryland / Dep		-	-	20770
		1 - State Registrar Ce	rtificate of Death		. No. 2000	
Physic		1. Decedent's Name (First, Middle, Last)  Charles William Todd		2. Date of Death Month Septembe:	r 1 2006	3. Time of Death 7:50 a. M
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Death	
		4349 Steeles Neck Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Vienna If Under 1 Year   II Under 24 Hrs.	8. Date of Birth	Dorches	ter  blace (State or Foreign
Funeral Director		214-20-8297 13 M 2 F 83 Yrs.	Months Days Hours Min.	Oct. 11	, 1922 Ma:	ryland
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le	ocation			Od. Inside City Limits
Maryl P-f sho	ţō	MD Dorchester	Vienna			1 ☐ Yes 2 X No
DEILIMOTE, INIGITYIGHTIG ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Itsm 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, its Michael Examinar must be notified at	Funeral Director	10e. Street and Number 4349 Steeles Neck Road	10f. Zip Code 21869	10g	. Citizen of What Cou USA	ntry?
deat deat	ner	11. Marital Status 12. Was Decedent Ever in U.S., Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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al Hyg	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)	
hould by Meni	မှ	Charles Burke Todd  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	Lizzie	Jones	Situar Tourn State Zin	Codel
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of Head					c. Location - City or To	
DAILLIMON  Sermit. Pages Depertment of mportent: if it iny injury or o		4 Donation 5 Other (Specify) Maryland			Murlock, Mi Meral Home	
Deperiment of the part in poor			2. Name and Address of Facility T 700 Locust St., Ca			r.A.
		23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		1	t,	Approximate Intervat Between Onset and Death
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law requires that the death certificate as been signed by the ettending phys 2 should be detached for use as the	Physician/Medi	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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ould b	ted b	Dementia, Anemia, Se	Zure durady	1 Yes	2 No 3 Prot	oably 4 Unknown
- o - o	Completed	heat direce face makes		24a. Was an autopsy performe	prior to co death?	psy lindings available mpletion of cause of
VICAL P sician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Deal	1 ☐ Yes 2 h (Check only one)	No 1□Yes	2□ No
Of V hysic this ce al direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie				'y)
on on other	tlon:	27. Manner of Death  12. Natural 5 Pending 2 Accident investigation  28b. Time of (Month, Day Year)	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	infury occurred	
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⊢ \$ ⊢ ŏ		plu Fin Chysician	1 DOOT 2255		9-01-	2006
		30. Name and address of person who completed cause of death (Item 23a) (Type Muhammad EJ93, M.D. 83 a Che	, Print)	nalis la	MX OI	112
S	tate	31. Date filed (Month, Day, Year) 32 degistrar's Signature	rayeare Dr. Cui	norlago	1 FIL 216	15
Regis		31. Date filed (Month, Day, Year) SEP 0 5 2006 32 legistrar's Signature				_

	1	For State Registrar	State of Marylan		nt of Heal			iene g. No. 200	6 2977
Physician /Medical Examiner		Decedent's Name (First, Middle, Last, Elmer Howard Tu a. Facility Name (If not institution, give	rnbaugh	4b. Ci	y, Town, or Loca		2. Date of Deat Month 09/	Day Year 01/2006 4c. County of Dea	3. Time of Death 9:25 P M
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be notified at	-	Journal Residence of Decedent  Oa. State 10b. County  MD Wicomico		y, Town or Location					10d. Inside City Limits 1 ☐ Yes XX No
r items 23a		0e. Street and Number  28207 Canterbury  1. Marital Status  1  Never Married 2 Married  3 WWidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1) XX es 2   No If Yes, Give Year or Dates:	S. 13. Was Der If Yes, s	801  edent of Hispani becify Cuban, Me	ic Origin? (Speaxican, Puerto F		Og. Citizen of What Court of WSA  14. Race - Am Black, Whith Specify: Wh	arican Indian, re, etc.
ygians. nerthan "natural", o it, the Medical Exan Completed by		15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or 5+)	16a. Decedent's U. (Give kind of life. DO NOT Ceramic	vork done during 'use retired)		ng	16b. Kind of Business	
marked other matic event, 1		7. Father's Name ( <i>First, Middle, Last</i> )  William Turnbaugh  19a. Informant's Name/Relationship ( <i>T</i> )		19b Mailing Addre	Mo	olly Be	ck	Maiden Surname)  City or Town, State,	Zio Code)
		Cathy Turnbaugh (d	laughter)	28207 Ca Place of Disposition (A emetery, crematory of	nterbur lame of rother place)	y Dr. S	alisbur ate	y, MD 2180 20c. Location - City or	1
important: if any injury or once.	Ī	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	Sun		and Address of F	Facility Bur	bage Fu	Berlin, MD neral Home MD 21811	
ysician ledical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of thimediate Cause (Final disease or condition resulting in death)	a Metastatic	not enter the m	ode of dying, suc	ch as cardiac o	r respiratory arro	est,	Approximate Interval Between Onset and Death
a burial-transit	រ៍	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary A  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	rtery Dise	ase				
detached for use as the detached for use as the detached for use as the Physician/Media	Dominio de la constanta de la	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic				23d. Date of de Month	livery Day Year
b ed y	5	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the underlying	g cause given in I	Part I.		pacco use contribute t es 2 □ No 3 □ P	o the cause of death?
ate has page 2		25. Was case referred to medical						y prior to ned? death? YOXNo 1 ☐ Yes	utopsy findings available completion of cause of
After this funeral di	2	examiner?  1 Yes XXNo  27. Magner of Death XXNatural 5 Pending 2 Accident investigation	Hospital: XX Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	Othor	☐ Nursing Hon		ence 6 Other (Spe ow injury occurred	ocify)
within 44 hours arier dearn. To the Funeral Director: After to completely filled in by the funeral Medical Certification:		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	(y)			City or Towr		
Fune ely fil		29a. Certifier (Check only one)  XX Certifying Phy 2 Medical Exami	sician: To the best of my kno iner: On the basis of examina and manner stated.						s stated. e to the cause(s)
o the Funer ompletely fil		29b. Signature and title of sertifier		1 2	29c. License num	nber	1 2	9d. Date signed (Mon	th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner Worcester 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min 1 □ M 2 F 2]3 -18 -4n(q Usual Residence of Decedent 7-30-Director deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "natural", or Items 23s or 28s-f show the Madical Examinar must be notilised at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 18 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) rivato DES 17. Father's Name 8. Mother's Name (First, Middle, Maiden Surname) (First, Middle, Last Be and Mental I ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zia Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 i Husband) Ocomoke Grai Janes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State permit. Page Department of Important: If any injury or ance. -9 owid 22. Name and Address of Facility Bennie 21. Signature of Funeral Service Licensee 5m Funcrel Home md. 2185, POCOMOKO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 terine **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intlated events resulting in death) Last Directo (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer should be d Division of Vital Records. δ 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate hes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a To the Funerel L the Hospital 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 - Market State 2006

29b. Signature and title of certifier

Ocomok egistrar's Signature

29c. License number

05542

29d. Date signed (Month, Day, Year)

			1- For Amend Items 27,280, F per	ME ME	artment of Health and 859,09715706dhb rtificate of Death	Mental Hyg	giene 2008	5 29779
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ALFRED H. TONRY			2. Date of Dea Month	ath Day Year ST 8 2006 4c. County of Death	3. Time of Death A
آلم	Examin	er	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL		4b. City, Town, or Location of Deat HAGERSTOWN		WASHING	ΓON
	Funeral Director		5. Social Security Number 235-28-3050 Sex 7. Age (In yrs. last	Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birt Month, Day 2/14/1	9. Birth WEST	pplace (State or Foreign VIRGINIA
	Maryland	lor	Usual Residence of Decedent		PCCALION RTINSBURG			10d. Inside City Limits 1  Yes 2  No
	with the 3a or 28a 1 be notifi	I Director	10e. Street and Number 327 W. KING STREET		10f. Zip Code 25401		10g. Citizen of What Cou	untry?
036	d within 72 hours after death with the Maryland Jiene. I than "natural", or Rems 23s or 28s-f ehow If a Medical Examinar must be notified at	by Funeral	11. Marital Status  1	1	Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puer 1 Yes 21 No Specify:	Specify Yes or No- to Rican, etc.)		, etc.
Baltimore, Maryland 21215-0036	1 within piene. r than	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) ORTICIAN	rking	16b. Kind of Business/I BROWN FUNERA	•
land	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last)  JAMES CHARLES TONRY			me (First, Middle, MATTHEV	Maiden Sumame)	
Mary	ges 1 and 2 should b it of Health and Ment if Itam 27 te marked or other traumatic		19a. Informant's Name/Relationship (Type, Print) ROBERT C. FIELDS/EXECUTOR	19b. Maili 22	ng Address <i>(Street and Number or Ri</i> O HOLDEN DRIVE, N	ural Route Numbe IARTINSBU	or, City or Town, State, Z JRG, WV 2540	ip Code) )3
imore,	Pages 1 a nent of Hes ent: If Itam ury or othe		A M Puriot 2 Commetice 2 Demonstrate State Comm	otery, cre DALE (		2006	20c. Location - City or 1 MARTINSBUR	
Balt	permit. Page Department i Important: If eny Injury or		21. Signature of Funeral Service Licensee Chaeles M. Blosen	2 T	BRÖWN "FUNERAL O'HÖME" P MARTINSBURI	.0. BOX 82 G, WV 2540	1, 327 W. KING	ST.,
1	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Fracture	Lç	ter the mode of dying, such as cardia    Compare	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner	Ļ	Due to (or as a consequent A Shive & L)	ce of): /	preumonia			
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (of as a consequent or constitution of the	tio		1/1	**A	
8760,	icate be executed physician and s the burial-transit	Ilcai	d.			Uml	D BY MEDICAL EXAMINER	
.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burral-transi	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deati	ath 3[	□Ectopic pregnancy □ Other (specify)	APPROVE	23d. Date of delin	very Day Year
α.	The law requires that ite has been signed b page 2 should be deta	۵	Part II. Other significant conditions contributing to death but not resulting the Tributing to death but not resulting	ıg in the u	inderlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
of Vital Records,		Completed	Hypatension Hypatidana					topsy findings available ompletion of cause of
f Vita	Physician: r this certific ral director,	To Be	25. Was case referred to sical examiner?  1 Defense 2 No Hospital: 1 Impatient 2 ER	/Outpatie	Othor	ath <i>(Check only o</i> Home 5 ☐ Resid	nne) dence 6 ⊟Other (Spec	ufy)
ion o	ling After Tune		5 Pending (Month, Day Year)	b. Time of Injury	Work?	28d. Describe h	now injury occurred	
Division	al or Attendi s after death. I Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	190600	reet, factory, office	/2009	Street and Number of Ru Rosebattik Wa	
	To the Hospital or Atte within 24 hours after de To the Funeral Dirscto completely filled in by th	edicai (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, deat and/or in	h occurred at the time, date and place evestigation, in my opinion, death occ	e, and due the time,	date and place, and due	to the cause(s)
	To th withir To th	Me	29b. Signature and title of centual Koz	CA.	29c. License number  D 0062223  Print)  Print)  Print HAG		29d. Date signed ( <i>Month</i>	, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23)	ia) (Type,	Print) MICLSTREET, HAG	CRSTOW	N, MO 2	1740
	Sta Registi		31. Date filed (Month, Day, Year) 22. Registrar's Signature SEP 1 5 2006	Spe	el e			

DHMH 17 Rev 1/2001

-lax TOME

		2	Ragistrar		Ce	rtificate of	Death	F	Reg. No.	29780
,	Physici /Medic	cal	Decedent's Name (First, Middle, La     Victoria	Lynn	Twigg			2. Date of Dea Month	Day Ye	3. Time of Death 13:50 M
	Examir Funeral	er	4a. Facility Name (If not institution, given MHS Brades Social Security Number 6. S 219-80-1780	dock Co	am pus (In yrs. last birthday) 47 Yrs.		r Location of Death  C C a H C  If Under 24 Hrs.  Hours Min.	8. Date of Birtl	4c. County of E Alleg	
O	Director	70	Usual Residence of Decedent  10a. State  MD  Allega		10c. City, Town or Lo	ocation nberland		iviay i	, 1959	10d. Inside City Limits 1 □X/es 2 □ No
with the M	3a or 28a-f	i Directo	10e. Street and Number 12702 Lippold W			10f. Zip Code	21502		10g. Citizen of Wha	t Country?
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 \( \text{Yes} \) 2 \( \text{Yes} \) If Yes, Give Year or Dates:	0	1□Yes 2□Xo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - / Black, V Specify:	American Indian, White, etc. White
<b>Maryland 21215-0036</b> 1d 2 should be filed within 72 hours aft	ygiene. her then "nat it, ine Medic	Completed	15. Decedent's E. (Specify only highest gra	ide <i>completed)</i> College (1-4or 5-	(Give		during most of work d)			ess/Industry ∋ Outdoor
ryland nould be fi	f Mental F narked ot natic ever	To Be	17. Father's Name (First, Middle, Last, James Twigg,	Sr.	T		Ruby N	Л. (Black	Maiden Sumame) burn) Twic	
e, Mar	lealth and m 27 Is n her traum		19a. Informant's Name/Relationship ( Richard Lippold		e 127	702 Lippol	d Way	Cum	r, City or Town, Star berland	MD 21502
Baltimore, Dermit. Pages 1 ar	riment of Frient: If ite		20a. Method of Disposition  1	y)	Sunset Me	matory`or other place morial Park	(e)   	8/1/2006	Cumber	
Ba Ba	Depar Impor any in		21. Signature of Funeral Service Licer	1. Scarpe	W.	108 Vii	sli Füneral F ginia Avenu	e: Cumbe	rland, MD 2	1502
/	nysician Medical kaminer		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SE	consequence of):	HOCK				Approximate Interval Between Onset and Death Hours
8760, cate be executed	physicien and is the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	consequence of):	CKFO	KKITOT	(And	EN WEDICAL EX	5 Howes
. Box 6	signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	, c	ELLECULION APPR	23d. Date of Month	
	been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to		e to the cause of death?  Probably 4 Unknown
	ete hes page 2	e Completed	25. Was case referred to medical						sy prior death 2 No 1 1	e autopsy findings available to completion of cause of h? Yes 2500
of Vita	<u>s</u> =	To B	examiner?	Hospital: npatien	t 2 ER/Outpatien	it 3 DOA Oth	26. Place of Deati er: 4 ☐ Nursing Ho		ence 6 □Other (S	Specify)
Division of or Attending Phys	death. tor: Afte the fune	Certification:	27. Manner of Death  Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by		Year) Injury	M 1 🗆	Yes 2 □No		ow injury occurred	
DIVI	ig is		4 Homicide determined	building, etc.				City or Town	n, State)	r Rural Route Number,
	within 24 hours a To the Funeral I completely filled	Medical	one)	ysician: To the best of ninar: On the basis of and manner state	examination and/or in	vestigation, in my o	pinion, death occurr	red at the time, d	ate and place, and	due to the cause(s)
P	To Cor	-	29b. Signature and title of certifier	Lam	r m	29c. Licens		_	July	
	( <i>O</i> Sta	te_	30. Name and address of person who DR, WILLAM LAM 31. Date filed (Month, Day, Year)	completed cause of dea	Seton Di	Print) Rive , Cu	omberla	nd, MD	21500	28,2006

Please Type or Print in Black Indelible Ink Marcus Woodland State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day September 2, 2006 0137 hrs **Medical Examiner** WOODLAND 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Capitol Heights Prince George's 5361 Sheriff Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or if Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Director Country WASH. 217-02-2136 08-23-1981 DC 1 X M 2 25 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 No ANNE ARUNDEL ODENTON 28a-f shov Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Montal Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. irector 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code  $\bar{\Box}$ U.S.A 21113 2104 PEACEFUL WAY, #304 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funera 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican. etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: BLACK If Yes, Give Year Yes 2 X No specify: Widowed Divorced 4 ⋛ 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) STUDENT N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WOODLAND VIOLET EDWARD INGRAM Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 9037 CONGRESS PLACE. LANDOVER, JOHN E. WOODLAND -FATHER MD 20785 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEM. 09-09-06 CLINTON, MD Donation 5 Other Specify 21. Signature of Euneral Service Licensee TAYLOR'S FUNERAL HOME NORTH CAPITOL ST., NW WASH, DC Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure List only one cause on each /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED physician the burial -Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed by 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No page 1 ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif 25. Was case referred to medical Be Hospital: 1 Inpatient Other<sub>4</sub> DOA Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 ဥ 1 V Yes 2 28a. Date of Injury (Month, Day Year) Sep 2, 2006 funeral 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Certification Subject was shot 0135 hrs Natural Division Yes 2 V No 5 Pending the 2 Investigation Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be or Town, State) 5361 Sheriff Road, Capitol Heights, MD Suicide determined (Specify) Parking Lot 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E September 2, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD

State Registra

31. Date filed (Month, Day, Year) **SEP 0 6** 2006

Registrar's Signature

06-06560 John Woodland

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No. 2005								006 2918	
Physicia		I. Decedent's Name (First, Middle,Last)	Month Day Year							
Medical Examin		JOHN E. WOODLAND  4a. Facility Name (if not institution, give street and number)	JR.		ity, Town, or	Location of	Septembe	r 2, 2006 4c. County of	0208 hrs	
		Prince George's Hospital Center			neverly	Location of	Death	Prince Ge		
Funeral	-		n yrs. last birth	hday) If	Under 1 Yea	r If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY)	Birthplace (State or	
Director		216-02-6390 1XM 2_F	29	Yrs.	onths Days	s Hours	Min. 08-19	9-1977	Foreign NEW YORK	
ž.	-	Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town	or Location					10d Inside City Limits	
daryland 28a-f show any <u>1 at once.</u>		MD ANNE ARUNDEL		BURN	IE				1 X Yes 2 No	
Maryla 28a-f	Director	10e. Street and Number		10f	. Zip Code		10	0g Citizen of Wha	ŕ	
ith the Maryland 23a or 28a-f sho notified at once		6436 ROOTS DRIVE			210	161		U.S.	Α.	
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	r in U.S.				n? (Specify Yes or No Puerto Rican, etc.)	<ul> <li>14. Race - White,</li> </ul>	American Indian, Black, etc.	
	•	1 Yes 2 X  Widowed 4 Divorced If Yes, Give Year	No	1 Ves	2 <b>X</b> No	snecify:		Specify:	BLACK	
urs aft tural'	좕	or Dates:  15 Decedent's Education (Specify only highest grade comple		Decedent's U	sual Occupat	tion (Give k	ind of work done	16b Kind of Bus	iness/Industry	
72 hor "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		during most o	•					
036 orthin ene. er tha	ᇍ	2		TRU	CK DR				IVATE	
15-0 Filed w Hygin d other		17. Father's Name (First, Middle, Last)					Name (First, Middle, M	,		
21215-0036 uld be filed within 72 hours af Mental Hygiene. marked other than "natural cevent, the Medical Examin	o Be	JOHN E. WOODLAND  19a. Informant's Name/Relationship (Type, Print.) (WIFE	198	Mailing Add	dress (Stree		LET II	NGRAM	State Zin Code)	
MD 2 id 2 shou lith and 1 m 27 is n		JANELLE CHAPMAN-WOODLAN			,		E, GLEN I	•		
ore, ME es l and 2 s. of Health ar If item 27 ther traums	ŀ	20a. Method of Disposition	20b. Place o	of Disposition ory or other p	(Name of cer		Date		City or Town, State	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itali: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.	1	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		RRECT		EM.	09-09-00	CLIN	TON, MD	
Baltimore, permit. Pages I an Department of He Important: If ite injury or other trees.	1	21. Sonature of Funeral Service Licencee			and Address		TAYLOR'S			
E.E.C.E.		15. E. Harkon		1722	NORT	H CA	PITOL ST.	.NW WA	SHINGTON.DC	
Physician /Medical		<ol> <li>Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.</li> </ol>	death. Do no	ot enter the m	ode of dying,	such as ca	rdiac or respiratory arre	est, shock, or hear	Between Onset and	
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)							Death	
- January		b	ence or):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ence of):							
ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseq	ence of):							
	n/Medical	UNPENDED AMENDED		•						
8760, iificate be ng physici	₩	IF FEMALE: 23c. If yes, outcome of	of pregnancy					23d. Date of c	lelivery	
687 ertific	jan/	3b Was decedent pregnant in the past 12 months?	C de ette	=		Ectopic	pregnancy	Month	Day Year	
Box 687 he death certific	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	e or death 5	Other	(Specify)			į.		
that the or		Part II. Other significant conditions contributing to death but	ıt not resultin	g in the under	rlying cause (	given in Par	t I. 23e. Did to	obacco use contrib	oute to the cause of death?	
P.G	d by						1 Yes	s 2 🗸 No 3	Probably 4 Unknown	
ords,	Completed						24a. Was autop		ere autopsy findings available ior to completion of cause of	
eco he law ite has	틹							rmed? de	eath? ✓ Yes 2 No	
ital Rec ician: The l s certificate rector, page	BeC	25. Was case referred to medical			26.Place		Check only one)			
Vite vysicis	0	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 🗸 ER/0	utpatient 3	DOA	Other <sub>4</sub>	Nursing Home 5	Residence 6	Other:	
n of \ iding Ph, h. : After tl	On: T	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year) Sep 2, 2006	28b. 1	Time of Injury 5 hrs		ry at Work? Yes 2 ✔	Subject was	how injury occurre s shot	d	
isior Attenc er death rector: by the	icat	2 Accident Investigation 28e. Place of Injury	r - At home, fa	arm, street, fa	ctory, office b	ouilding, etc	28f. Location (	Street and Number	r or Rural Route Number, City	
Division ospital or Attend hours after death hours after death neral Director: y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Parkii	ng Lot				or Town, S 5361 Sherif	<sup>State)</sup> f Road, Lando	over, MD	
Ho Fu		29a. Certifier 1 Certifying Physician: To the best of my krone) 2 Medical Examiner: On the basis of examin								
To the within 2 To the complet	Medical	and manner stated  29b Signature and title of certifier		- '	29c. Licens				d (Month, Day, Year)	
2		Albra Brasse Will	-		o.c.	M.E.		September		
1/6)	1	30. Name and address of person who completed cause of deal	h (Item 23a)							
of		Melissa Brassell, MD Assistant Medical E.		111 Penr	n Street, E	Baltimore	, MD 21201			
Sta Regist		31. Date filed (Month, Day, Year) 22. Registrar's SEP 0 6 2006	Signature,	1						

			For State Registrar	State of Maryland	d / Depa	artment of H	lealth and M Death		ene2006 1. No.	29784
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death	Day Year	3. Time of Death
	/Medic	ai	Ellen Juanita V			4h City Town o	r Location of Death	Aug. 30,	4c. County of Deat	3:10 p M
	Examin	er	Talbot Hospice			75. 5ky, 15km, 5k	Easton		Talbo	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign
	Director		213-22-9/11	78 <b>7</b> 8	Yrs.			April 7,	1928 Ma	ryland
	land w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d, Inside City Limits
	Maryland	tor	Maryland Dorch	nester	Ea	st New Ma	arket			1 ⊡Yes 2 □ No
5	th the or 284	Jirec	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Co	
3	ath w	rai	1912 Academy St.			<u> </u>	21631		US 14. Race - Ame	
ر 36	s after death with the Marylar , or Items 23e or 28e-f ehow cominer must be notified at	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc.
ခို	2 hour	edt	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occup	ation	. 16	Sb. Kind of Business/	i <u>ite</u> Industry
215	hin 72 an "ne Medis	Completed	(Specify only highest grade Etementary/Secondary (0-12)	de completed)  Coltege (1-4or 5+)	(Give life. l	kind of work done of OO NOT use retired	during most of work d)	ing		
21	ed with	Сош	8			Homem			Own H	lome
and	be file	Be	17. Father's Name (First, Middle, Last) Samuel H. Abey					e (First, Middle, Ma illian Go		
ž	12 should be filed within 7: h and Mental Hygiene. 7 is marked other than "n treumatic event, the Medi	ဥ	19a. Informant's Name/Relationship (7	voe. Print)	19b. Mailir	ng Address (Street			City or Town, State, 2	Zip Code)
ĕ	nd 2 s llth an 27 is i	9 8	Terri L. Wrigley		1	-	s Island 1			21648
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-4 ehov any injury or other treumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 :  4 Donation 5 Other (Specify	Removal from State	lace of Dispo	sition (Name of natory or other place rMemPark	(90)	Date 20	oc. Location · City or Cambridge,	
Balti	permit. Departm Importer any inju	1	21/Signature of Furferal Service Licens	- Bonus	el 3	Name and Aldre ULTIN- T US High	ss of Facility mwell Fun St., Cambr	neral Hou	e, 1.A. 21613	
	Physician (Medical Examiner paris)	Examiner	23a. Part 1. Enter the dise se, or comp shock, or hear I if if it. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cau e on each line.	CAA uence of):	-	ng, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Ponset and Death
Box 68760,	leath certificate be execul s attending physician and d for use as the burial-trar	icai	tF FEMALE:	d					23d. Date of de	iven
P.O. Bo	that the death or ed by the atten detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			Month	Day Year
	sign sign d be	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes		the cause of death?
l Reco		Completed						24a. Was an autopsy performe 1 ☐ Yes 2 ☐	24b. Were au prior to death?	utopsy findings available completion of cause of
/ita	iysicien: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth		h (Check only one)		
Division of Vital Records,	ng Phys fter this ineral di	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	4   Nursing no	me 5 ☐ Residen 28d. Describe how	ce 6  Other (Spe	cify)
Divisi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ro State)	ural Route Number,
	he Hospit n 24 hour he Funere pletely filk	Medicai (	29a. Certifier (Check only one) 1 ☑ Certifying Ph	/sicien: To the best of my know iner: On the basis of examinat and manner stated.	wledge, deatl tion and/or in	n occurred at the tir vestigation, in my o	me, date and place, opinion, death occurr	and due to the cau red at the time, date	se(s) and manner as e and place, and due	s stated. to the cause(s)
	To t with: To t	Σ	29b. Signature and title of certifier  MCAH	Sunt		29c. Licens	a number /	290	1. Date gigned (Mont	n, Day, Year)
			30. Name and address of person who of Dr. David Smith,				MD 21601			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Begistrar's Signa	ture	•	EID ZIOUL			
	Regist	rar	SEP 0 1 2	006	B 1	north)				
DI	HMH 17 Rev 1/2	001		ET.	1					

			For State	State of M	laryland /		nt of Health			2000	29785
1	29	- 4	Registrar  1. Decedent's Name (First, Middle, La.	St)		Continue		2. 0	ate of Death	. No.	3. Time of Death
	Physici /Medic		Joseph	L.	Wood	land	Sr.	A	1945+	29, 2006	10:45 A M
	Examin	er	4a. Facility Name (If not institution, give	11	)	4b. Cit	y, Town, or Location	n of Death	í	4c. County of Death	
	Funeral		5. Social Security Number 6. S	Home 7. A	ge (In yrs. last t			or 24 Hrs. 8. D	ate of Birth	9. Birth	place (State or Foreign
No.	Director		212-24-4986 1	<b>X</b> M 2□ F	78	Yrs. Month	s Days Hours	Min. MA	Month, Day, Y	428 MA	reyland
	and ow	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location					10d. Inside City Limits
	Mary Mary Lied	to	Marsland St. 14	ARYS	C	narlotte	. Hall				1 X Yes 2 ☐ No
	or 28s	Oirec	10e. Street and Number		111 6	10f.	ip Code		10g	. Citizen of What Cou	intry?
	s 23a	erai	29449 Char	13 Was Danden	A   (	-d	20622		Voc or No	14. Race - Amer	iogo Indian
"	ritem ritem	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give	? ] No		edent of Hispanic C pecify Cuban, Mexic		n, etc.)	Black, White	
5-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow lisst Esaminer must be multified at	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates	1951-7	1  Yes	2 No Specif	'y:		Specify: 3	lack
15-(	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		ia. Decedent's Us (Give kind of s life. DO NOT	vork done durina m	ost of working	16	b. Kind of Business/li	ndustry
2121	d within giene. rr than "	omo	Elementary/Secondary (0-12)	College (1-4or	5+)	5	taff	Set.		Army	
	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last,		11.1	11 1	18. Mot	her's Mome (Fire	st, Middle, Ma	iden Sumame)	1
Maryland	should be ind Mental I	၉	19a. Informant's Name/Relationship (	Type Print)	MODU	HANG Sh Mailing Addre	ss (Street and Num	GNES	C Number (	City or Town, State, Zi	in Code)
S	nd 2 alth a 27 ts		Theresa R. State	en - Grand	/Day -	7 Flath	1 21	Staf	Porce	1/	2554
ore,	es 1 and of Health fitem 27 ir other tr	- 3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20000	of Disposition (A	ame of	Date	20	c. Location - City or T	
Baltimore	permit. Pages 1 a Department of Hes Importent: If item eny injury or othe		4 Donation 5 Other (Specif	y)	MID	Vetern	s Cem_	9/6/06	. C	heltenham	Maryland
Bal	permit. Departr Importe eny inj		21. Signature of Funeral Service Licer	(1)	191	22. Name	and Address of Fac	Home f	4 1	w	0 300
			23a. 1rt1. Enter the Isease, or com shock, or heart failure. List only	p cations that cause	ed the death. Do	o not enter the m	ode of dying, such a	as cardiac or res	piratory arres	10030	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ME	tasta.	tic /	une C	4ncer			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequenc	e of):	7	, , , , ,			
Æ	6	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequenc	e of):					
	cuted nd ransit	amin	that miliated events	c							
8760,	ate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or a	s a consequenc	e of):					
687	ficate physics the b	edice		d							
Вох	leath certificate b attending physic I for use as the b	M/UE	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2  Fetal dea	th 3⊡Ectopic	pregnancy			23d. Date of defin	,
	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		at time of death	5 Other				Month	Day Year
P.0	res that th signed by be detac		Part II. Other significant conditions of	ontributing to death	but not resulting	in the underlying	cause given in Par	tl.	23e. Did toba	cco use contribute lo	the cause of death?
Records,	quires an sign uld be	Completed by	CHRUWIC	UBSTRUC	-tive	Ling	Disea	se	1 Yes	2 □ No 3 □ Pro	bably 4 Unknown
000	law requir as been si 2 should	plet							24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
	: The cate h	Con							performe	d? death? No 1 ☐ Yes	2 🗆 No
of Vital	Attending Physician: It death. sector: After this certificiby the funeral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆 ER/0	Outpatient 3	0	ce of Death (Ch			<b>Z</b> .)
J Of	g Phy ler this neral d	n: To	27. Manner of Death	28a. Date of In	jury 28b	Time of Injury	28c. Injury at Work?		-	ce 6 □Other (Specinjury occurred	ny)
Sior	tendin eath. tor: Af the fur	catic	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	1		М	1 Tes 2				
Division	l or At after d Direct	Certification:	4 Homicide determined	289. Flace of II	nfury - At home, etc. <i>(Specify)</i>	farm, street, fact	ory, office		ocation (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowled	ge, death occurr	ed at the time, date	and place, and o	lue to the cau	se(s) and manner as	stated.
	the Ho nin 24 the Fu	Medical	one)	and manner	or examination a stated.					and place, and due	
	To To Con	2	29b. Signature and title of certifier	111			9c. License numbe		290	Date signed (Month	, Day, Year)
٢			30. Name and address of person who	co/ng/eted cause of			1) 12906	, ,		0/29/06	
1	B3		12070 OD 41			klald	of M	ARTAND		20602	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Re	trar's Signature	4. Som	E .				

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State of Mar	yland / Depart	ment of Health	n and Mental I	Hygiene	2001

			1- State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death	ental Hygie	
	<b>L</b>		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medio		ARNOLD WILSON		09 0:	3 2006 3:45 A M
H	Examir	er	4a. Facility Name (If not institution, give street and number)  25535 STILL POND NECK ROAD	4b. City, Town, or Location of Death WORTON		4c. County of Death KENT
	Funeral Director		5. Social Security Number $218-20-6681$ 6. Sex $1 \times 1 \times 1 \times 1 \times 1 \times 1 \times 1 \times 1 \times 1 \times 1 $	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, You 03 06	ear) 9. Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryla f sho	5	MD KENT WORTON			1 ☐ Yes 2X No
	128a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	th with		25535 STILL POND NECK ROAD	21678		USA
	ems er	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by FL	1 Nover Married 2 Married 1 TVes 2 No	1 ☐ Yes 2 No Specify:		Spec BLACK
21215-0036	within 72 hours after death with the Maryland ene. than "natural; or Items 23e or 28e-f show the Medical Evarilies results to trafficed at	ed t	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	b. Kind of Business/Industry
215	thin 7.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		
2	filed wil Hygien other th	Con	11th CONS	TRUCTION FORMAN	,	OCAL 222
Maryland	d d d d	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Sumame)
Ž	s 1 and 2 should f Health and Mer itam 27 is marke othar traumatic	ဥ	OLIVIER J. WILSON  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	ing Address (Street and Number or Rur	WILMORE al Route Number, C	lity or Town, State, Zip Code)
	ith an			Springton RD Up		
altimore,	of Hea				-	c. Location - City or Town, State
Ē	Pages ment of I ant: If its ury or o		`4 □Donation 5 □ Other (Specify) NC	COL 9/9/		RTON, MD
Balt	permit. Pages Department of Important: If it any injury or o		21. Signly ture of Funeral Service Licensee 2  22. Signly ture of Funeral Service Licensee 2  23. Signly ture of Funeral Service Licensee 2  24. Signly ture of Funeral Service Licensee 2  25. Signly ture of Funeral Service Licensee 2  26. Signly ture of Funeral Service Licensee 2  27. Signly ture of Funeral Service Licensee 2  28. Signly ture of Funeral Service Licensee 3  29. Signly ture of Funeral Service Licensee 3  29. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  21. Signly ture of Funeral Service Licensee 3  29. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service Licensee 3  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  21. Signly ture of Funeral Service 1  22. Signly ture of Funeral Service 1  23. Signly ture of Funeral Service 1  24. Signly ture of Funeral Service 1  25. Signly ture of Funeral Service 1  26. Signly ture of Funeral Service 1  27. Signly ture of Funeral Service 1  28. Signly ture of Funeral Service 1  29. Signly ture of Funeral Service 1  29. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funeral Service 1  20. Signly ture of Funer	2. Name and Address of Facility $K$ $en$ $ervice$ $821$ $W.$ $S$	neth Wal	lley Funeral polis, MD 21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		Λ	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	structe la	lmonor	y Vislase
	/Medical Examiner		Due to (or as a consequence of):			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ficate be executed physician and sthe burial-transit	Examiner	that initiated events c.			
8760,	be exe		resulting in death) Last Due to (or as a consequence of):			
687	tificate ng phys as the	edicai	d			
Box (	ath cer attendir for use	Physician/M	in the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	nat the d by th setach	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the t	inderlying cause given in Part I	23e Did tobac	co use contribute to the cause of death?
Records,	w requires that the di been signed by the should be detached	d by		1 dent	1 ☐ Yes	2 No 3 Probably 4 Unknown
CO	aw req 1s beer 2 shou	oiete			24a. Was an	24b. Were autopsy findings available
	The lay	Completed			autopsy performs 1 Yes 2	prior to completion of cause of death?  No 1 □ Yes No
Viital	ysician: The is certificate h director, page	Be C	25. Was case referred to medical examiner?		h (Check only one)	
<u>o</u>		2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		me 5 Residence	e 6 Other (Specify)
UO	Attanding Physician: or death. actor: After this certification of the funeral director.	tion	27. Manner of Death  28a. Date of Injury 28b. Time ( 28d. Date of Injury 28b. Time ( 28d. Date of Injury 28b. Time ( 28b. Tim	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	ZOG. D'ESCRIDE NOW	injury occurred
Division of	l or Attano after death Diractor:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attanding Ph within 24 hours after death. To the Funarel Diractor: Atter th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
1	4		· / / - / /	D0051784		7-5-00
,	7		30. Name and address of person who completed cau of death (Item 23a) (Type		***	T AND 04400
7	CA	• 0	ANDREW S. FERGUSON MD 120 SPEE  31. Date filed (Month, Day, Year)  32. Regis s Signature		IN, MARY	LAND 21620
	Sta Registi	-	SEP - 6 2006	A CONTRACTOR OF THE PARTY OF TH		

Division of Vital Records, P.O. Box 68760.

		1 = For State Registrar	State of Maryland / De	partment of Health and M <i>ertificate of Death</i>	lental Hygiene .Reg. No.	2006 2978
		Decedent's Name (First, Middle, Last			2. Date of Death Month Day	3. Time of Death
Physic /Med			NELL WEEDON		September	1 2006 2:24 PM
Exam	iner	4a. Facility Name (If not institution, give FREDERICK MEM		4b. City, Town, or Location of Death		County of Death
Funera	1	Social Security Number 6. S	ex, 7. Age (In yrs. last birthda		8. Date of Birth	9. Birthplace (State or Foreign
Directo		110-21-3850	M 2□F 54 Yrs.	Months Days Hours Min.	(Month, Day, Year) 9-15-51	9. Birthplace (State or Foreign Country)
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
Marylan a-f ehow	tor	Md. Frede	rick Frede	rick		1 ✓ Yes 2 ☐ No
ith the Maryla or 28a-f ehov	Director	10e. Street and Number	GATE DRIVE	10f. Zip Code		zen of What Country?
deeth with the Maryland me 23a or 28a-f ehow	Funeral	122 STONE		2/703  3. Was Decedent of Hispanic Origin? (Sp.		14. Race - American Indian,
after or Its	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>□ Yes 2 No Specify:</li> </ol>		Black, White, etc.
hours ural',	ed by	3 Widowed 4 Divorced	Year or Dates:	cedent's Usual Occupation		Specify: BLACK
CI 6 19	plete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Gi	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)	ing	nd of Business/Industry
filed within 7 Hygiene. other than "n	Completed	1274	LF	ABORER		NSTRUCTION
ed la b	Be	17. Father's Name (First, Middle, Last)  Charles Lee			e (First, Middle, Maiden 2005e BOL	Jan Control of the Co
should nd Mer mark	2	19a. Informant's Name/Relationship (7	Type, Print) 19b. Ma	illing Address (Street and Number or Run		
and 2 salth a n 27 le		Carolyn Weed.	,	ST. Laurence		derick Md. 21701
Pages 1 nent of He int: If Itsn		20a. Method of Disposition  12 Burial 2 Cremation 3	Removal from State cemetery, c	rematory or other place)		cation - City or Town, State
그는문금	اد	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	) Bartons	ville Cem. Sept 22. Name and Address of Facility 100	1,1006 Bart	ensville pld.
Deper Impo		> bay x. k		GARYL, ROUNS FUN		
		23a. Part1. Enter the disease, or company shock, or heart failure. List only	plications that caused the death. Do not e			Approximate Interval Between
Physiciar /Medica		tmmediate Cause (Final disease or condition resulting in death)	a fitherosclero:	tic Curdiovase	vlav Di	Scase Years
Examine			Due to (or as a consequence of):			
בי פ	ner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
xecute and II-trans	Examiner	that initiated events resulting in death) Last	c			
icate be executed physicien and s the burial-transit	edical E		d			
	Medi	tF FEMALE:				
leath certific attending	Physician/M	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)	2	23d. Date of delivery Month Day Year
t the de	hysic	1 Yes 2 No 9 Unknown	9 Unknown	S Other (specify)		
The law requires that the death cert tie has been signed by the attending page 2 should be detached for use a	by P	4 /	ontributing to death but not resulting in the	underlying cause given in Part I.		se contribute to the cause of death?
requir seen si hould		- Hyper	tension		1 Tes 2	No 3 Probably 4 □Unknown
The law ate has t page 2 s	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	a	25. Was case referred to medical		26. Place of Deatl	1 Yes 2 No	1 ☐ Yes 2 No
hysici this cer al direc	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ER/Outpat	ient 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6	G □Other (Specify)
ding P h. After t funera	ion:	27. Manner of Death  1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury	r occurred
Attending Physician: r death. ector: After this certifice by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - At home, farm,			d Number or Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		4   Hornicide	building, etc. (Specify)		City or Town, State)	
Hospital 24 hours a Funeral I	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)
ro the within Fo the comple	Me	29b. Signature and title of certifier	and marrier stated.	29c. License number	29d. Date	e signed (Month, Day, Year)
<u></u>		alun Ke	line del	D37197	9-	2-2006
5		30. Name and address of person who	completed cause of death (Item 23a) (Typ	e, Print) 7 14	1 1 T 1	2-2006 rick, MD21701
S	tate	31. Date filed (Month, Day, Year)	32. Radistrar's Signature	West / 59	red   rede	man 1-1/101
		CEDAR	Anne Ma			

			1 - For State Registrar	State of Mary	Ce.	rtificate of	Death		g. No.	Ub	29/8
	Physici /Medi		Decedent's Name (First, Middle, Las     KEVIN REEVES	,				2. Date of Death Month SEPT		Year 06	3. Time of Death 2:37 Рм
	Examir		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of	of Death	
	Funeral		20424 BOLAND 5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year	ANTOWN  If Under 24 Hrs.	8. Date of Birth	MONTG		
Į,	Director		219-12-4451	M 2□F 81		Months Days	Hours Min.	EB 24	7925	Coun	lace (State or Foreign try) MD
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	ctor	Usuel Residence of Decedent  10a. State 10b. County  MD MONTG	GOMERY 100	c. City, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 No
	h with th	Funeral Director	10e. Street and Number 20424 BOLAND	FARM ROAD		10f. Zip Code 208	76	10	g. Citizen of W US		try?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "naturel; or iteme 23a or 28a-f ehow appringury or other traumatic event, the Madical Examinar must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Nover Married 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hif Yes, specify Cuba	dispanic Origin? (Spe an, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	Black	- Americ , White, WHI	
0-C17	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	1	6b. Kind of Bus		·
12 DU	al Hygien t other th	Be Con	11 17. Father's Name (First, Middle, Last)		FARM	ER	18. Mother's Name		AGRICI		JRE
aryiand	should tind Ment o marked umatic d	To	EUGENE WADE  19a. Informant's Name/Relationship (7)	Type, Print)	19b. Mailir	ng Address (Street	And Number or Rural		City or Town, 5	State, Zip	Code)
ē Š	1 and 2 Health a tem 27 le		CHUCK WADE / CC  20a. Method of Disposition	USIN	Ob. Place of Dispo	sition (Name of	ADAMSTO	ate 2	21710		wn. State
Бант	t. Pages rtment of rtant: If i		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify	,			ETERY 9/6	100	BARNES		
מ	Depar Impo		21. Signature of Funeral Service Licen	see .	22	Name and Addre HILTON 22111	ss of Facility FUNERAL BEALLSVII	HOME	, BARI	NESV	ILLE, MD
	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only a limmediate Cause (Final disease or condition resulting in death)	one cause on each line.  aPANCREAT  Due to (or as a cou	IC CANC	·	ng, such as cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
,00	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor							
oo voo vo	± 0 €	/Medical	IF FEMALE:	d	egnancy				23d. Date	of daliva	
	the death by the atter ached for u	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnancy Other (specify)	<u>'</u>		Mont		Day Year
cords, r	quires that en signed t	þ	Part II. Other significant conditions or	ontributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.			oute to the	e cause of death? ably 4 Unknown
ם מינים	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours alter death within 24 hours alter death. To the Lonerib Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Completed						24a. Was an autopsy perform	ed? de	ere autorior to consath?	osy findings available apletion of cause of
N   G	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death				
5	Phys rthis sraldi	۲. ا	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	t 3 DOA 28c. Injun	er: 4 Nursing Hom	e 5 Residen			)
NISION NISION	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Director.	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Yea	ir) Injury	M 1	k? Yes 2 □ No				
2	oital or A urs after orel Direction by		4 Homicide determined	building, etc. (S)	pecify)			BI. Location (Stre City or Town,	State)		
	the Hosp in 24 ho the Fund pletely fi	ledical	one)	ysician: To the best of my iner: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	use(s) and man ee and place, ar	ner as sta nd due to	ated. the cause(s)
	Con Con	W	29b. Signature and title of certifier  Paul Barrier  30. Name and address of person who described to the second se	completed cause of death	(Item 23a) (Type.		60335		d. Date signed		200 6
			PAUL BANNEN,	MD 18111 F	RINCE E	HILIP D	OR., OLNE	Y, MD	20832	)	
	Sta Registr		31. Date filed (Month, Day Year) 5 2	32. egistrar's S	ignature	ande					
DHN	AH 17 Rev 1/2	001						-			

DHMH 17 Rev 1/2001

06-06522 Please Type or Print in Black Indelible Ink Timothy Wayne Wisner State of Maryland / Department of Health and Mental Hygiene 2006 29789 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 31, 2006 0815 hrs **Medical Examiner** Timothy Wayne Wisner, Sr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Anne Arundel 8131 Oakwood Road Glen Burnie 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5 Social Security Number **Funeral** Foreign MD Months Davs Hours March 6, 1945 Director 61 212-44-8450 1 X M 2 F Usual Residence of Decedent 10a State 10b County 10c, City, Town or Location 10d. Inside City Limits Yes 2 X No or items 23a or 28a-f show must be notified at once. Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ۵ USA 21061 8131 Oakwood Road Funeral Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X No Yes 1 Yes 2 X No specify: White 3 Widowed 4 Divorced If Yes, Give Year Specify: the Medical Examiner à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than Building Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Painter 9 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filed ment of Health and Mental Hytant: If item 27 is marked of or other traumatic event, the Nellie Agnes Cheilsman Be Milton Scott Wisner, Sr. 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 Commons Way Palm Beach Gardens, FL 33418 Timothy W. Wisner, Jr/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 09/02/06 Beltsville, MD Chesapeake Crematory Other Specify. 22. Name and Address of Facility
Going Home Cremation Service 21. Signature of Funeral Service Licenses P,0, Box 784 Clarksville, Beverly L. Heckrotte, P.A. MD Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure List only one cause on each line /Medical Death a Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last Physician/Medical AMENDED UNPENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Be

Division of Vital Records, P.O.

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Medical

				performed? 1 ✓ Yes 2 No.	1 Yes 2	
25. Was case referred to medical			26 Place of Death (Che	eck only one)		_
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nu	rsing Home 5 Residence	e 6 🗸 Other. Scene	
27. Manner of Death	28a. Date of Injury FOUND: FOUND:	28b. Time of Injury FOUND:	28c. Injury at Work?	28d. Describe how injury Subject hanged sel		

Aug 31, 2006 0800 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 8131 Oakwood Road, Glen Burnie, MD determined (Specify) Single Family Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

O.C.M.E.

August 31, 2006

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

31 Date filed (Month, Day, Year) State 2006 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Robert Norman 30 2006 Young August 7:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3611 Fox Run Road East New Market Dorchester 8. Date of Birth (Month, Day, Year) May 30, 1929 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours Pennsylvania 1 X M 2 □ F 77 May 208-22-2831 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23a or 28a-f show 1 ☐ Yes 2X No Directo Maryland East New Market Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Itema 23a 3611 Fox Run Road 21631 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 107 14. Race - American Indian, 11 Marital Status 1 ⊠Yes 2 No 1947− If Yes, Give Year or Dates: 1950 Black, White, etc. the Medical Examiner filed within 72 hours after 1 ☐ Never Married 2 X Married ŏ 1 ☐ Yes 2 X No Specify: <u>8</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Salesman Automobile 12 Pages 1 and 2 should be filed nent of Health and Mental Hygisht: If item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Carl Young Agnes Caswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 Fox Run Road, East New Market, MD 21631 Patricia L. Young/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 9/1/2006 Delmar, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, Signature of Funeral Service Lig MD 21631 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Viete (lee wurte **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). ettending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 □Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s autopsy performed 1 ☐ Yes 20 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ \M6 this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; s after de. 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29 a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3988 who completed cause of death (Item 23a) (Type, Print)

State Registrar David

31. Date filed (Mo

Smith, M.D.

0ar 1 2006

Baltimore, Maryland 21215-0036

Records. P.O. Box 68760.

Division of Vital

32 Aegistrar's Signature

29466 Pintail Drive - Suite 5

Easton,

Ms

			Please	Type or Print in B State of Maryland			-	_	jible.	
			1 - For State Registrar	Otate of Maryland		ate of Death		Reg. No.	106	29791
	Physici		1. Decedent's Name (First, Middle, La	F. YOUN	C		2. Date of De. Month	Day	Year 2006	3. Time of Death
	/Medic Examin		4a. Facility flame (If paying tution, or			ty, Town, or Location of Death			ty of Death	4
			9211 Sturf Land 5. Social Security Number 6.3	Sex 7. Age (In yrs. It	a et hirthday) If Und	lenfor MD. L. Jer 1 Year   If Under 24 Hrs.	735 8. Date of Bird	P	G. Co	ace (State or Foreign
	Funeral Director		220-40-5040	12XM 2□F 62	Month		(Month, Da	y, Year) 2, 1944	Mary	
Cocio	MON III		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location				10	d. Inside City Limits
M o	Ba-f st	Director	Mangland Prince	George 1	Clintun					1 ☐ 785 2 ☐ No
backack with the Mandage	n'netural', or items 23a or 28a-f show		10e. Street and Number	rd St	10f. 2	Zip Code 2073		10g. Citizen o	SA	try?
1	ems 2	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was De	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puer	pecify Yes or No to Rican, etc.)		ace - America lack, White, e	
-003c	l', or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 MYes 2 □ No If Yes, Give Year or Dates: 1965 -	-(2) 1 Yes	2 ☐No Specify:		Spec	BL	ocle
3-0030	netura		15. Decedent's E	ducation	16a. Decedent's U.	work done during most of wo	rking	16b. Kind of	Business/Ind	
1215 2 Signature	r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	tenance	-	La < Ro	i ale	Service
אַ סְר	ent,	Be Co	17. Father's Name (First, Middle, Las	)	1 171 (171		ne (First, Middle,	Maiden Sum	ате)	1
	marked c	ToE	Frederick B	Young		Henrie		- F	rederic	lc
	4 0 - 0		19a. Informant's Name/Relationship	1 Sister	9254 P	SCA+AWA	2 C	ate	m, State, Zip	2 0735
Je,	of Health item 27 rother tr		20a. Method of Disposition	20b. P	lace of Disposition (femetery, crematory of	lame of	Date	20c. Location	n - City or To	
	Department of himportent: if ite eny injury or of once.		1 Maurial 2 □ Cremation 3 0 '4 □ Donation 5 □ Other (Spec	m 5+	. Jush	Cath Ch 9/8	3/06	Mores	pn 2A	(41)
Bal	Depertiment import eny inj	1	21. Signature of Juneral Service Lic.	nsee	. 1	and Address of Facility	time 1/4	Au	M	1) 7,668
	CID.		23a. Part1. Enter the isease or conshock, or heart ailure. Lis		1 / 101		c or respiratory a	rrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	a ATTHEROSCLE		andio vasul				Onset and Death  2 Years
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					0
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence ot):					
	sicien and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					
	sicien /sicien e buria	ā		d	· 					
200	ing phy e as th	Medi	IF FEMALE:							
ROX	death ceitificale to a stending physion of for use as the b	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3 □Ectopic	pregnancy (specify)			Date of delive Month	ry Day Year
J.	igned by the a be detached f	hysi	9 🗌 Unknown	9□ Unknown						4.411.0
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ō	a rhis eral dii	n: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time of	DOA 4 2 Nursing 1 28c. Injury at Work?	dome 5 ☐ Resi 28d. Describe			")
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	vithin 2 Fo the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date sign	ned (Month, I	Day, Year)
, '	2 - 0		> msil-			DY5365			7-05-	
9	REEL		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)	m RJ 4101 f	of WAS	Ligton	MO?	-78C
		ate	30. Name and address of person who will chall Siden  31. Date filed (Month, Day, Year)  SEP 0 6	32. Figistrar's Signa	atury Annu	6)				
	Regist	rar	SEP 0 6	LUUD PROCESS.	No Property					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16, 2006 Physician 10:03 A M Adkins September Robert Tee /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins - Bayview Center Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth Month, Day Xear) January 23, 1928 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F 232-34-8549 78 Yrs. West Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, it is Medical Examinar must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Dundalk Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 7407 Belclare Road Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Steel 8 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Olga Adkins Albert Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1928 Cedar Lane, Dundalk, MD. 21222 Brenda Kelly Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1 Durial 2 Cremation 3 Removal from State East Lynn, West Virginia Everett-Adkins Cemetery 22, 2006 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundla, MD. 21222 tris m 23a. Pant/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and U-ath 521515 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner LUNG CARCINIMA CMOLL CELL Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Ng. The law requires that the death certificate be executed buriai-transil Due to (or as a consequence of): attending physicien for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) be detached of Vital Records, P.O. 9 Unknown signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by FIBRILL OTH ATRIAL 3 ☐ Probably 4 ☐ Unknown Yes 2 No should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has autopsy perform 1 Yes 2 No certificete Physician: 26. Place of Death (Check only one) director. Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this After thi 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Attanding 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident filled in by the within 24 hours efter deal To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/18/06 D18642 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. PAMAMEM, W.D. STIY. BPHILIADILINA ND. BOT, V 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 0 2006 Registrar

		1.	For State Registrar	State of Mar		partment of I ertificate of					2006	29793
	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		Lucia M. Ar	ellano					Sept 7		6	9:00 A M
	Examin	er	4a. Facility Name (If not institution, giv 1419 Ashton Road			4b. City, Town, Ashton					ounty of Death	ÿ
	Funeral Director		220 ) 1 3 100		79 Yrs. last birthda 79 Yrs.	y) If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birt (Month, Day Nov 26	h , 1926	Cou	place (State or Foreign ntry) Lippines
	and and		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or	Location						10d. Inside City Limits
	Maryl -f sho	ţō	Maryland Prince	George's	Upper N	Tarlboro						1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number			10f. Zip Code				10g. Citize	n of What Cou	ntry?
	th with	alD	12300 Wallace	Lane		20	)772			Unit	ed Star	ces
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or itsme 23s or 28s-f show says injury or other traumatic event, the Marical Examiner must be nullised at anone.	by Funeral	11. Marital Status  1 Never Married MM Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 You If Yes, Give Year or Dates:	er in U.S.	B. Was Decedent of II Yes, specify Cub	Hispanic Or lan, Mexica Specify	n, Puerto Ri	ify Yes or No- ican, etc.)		. Race - Ameri Black, White pecify:	
9	2 hou		15. Decedent's E	ducation	16a. Dec	edent's Usual Occu	pation	at of working	.	16b. Kind	of Business/Ir	ndustry
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<u>ya</u>	Ment Ment arked atics	Tof	Eugenio Manansa				<u> </u>		Munoz			
, Mar	and 2 shi salth and n 27 is m sr trsum		19a. Informant's Name/Relationship (Ferdinand M. Arel		19b. Ma 812	Milestone	and Numb Driv	er or Rural i re, Si	Route Numbe 1ver S	r, City or T pring	own, State, Zi	20904
Baltimore, Maryland 21215-0036	Pages 1 nent of He ant: If itsn ury or oth		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special		cemetery, ci	position (Name of ematory or other pla nd Veterai	s Cen	ot 13°, netery	<sup>te</sup> 2006		tion - City or T enham,	own, State Maryland
Balt	permit. Departr Imports sny Inj.		21. Signature of Funaral Service (199	M.		22. Name and Addr Alexandria						
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8760,	eath certificate be executed attending physicien and for use as the burial-transit	ai Exar	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
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Division of Vital Records, P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funsrel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【INo 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	B Ectopic pregnanci i Other (specify)	у			230	d. Date of deliv Month	ery Day Year
rds, P	w requires that been signed b should be deta	ed by Pł	Part II. Other significent conditions	contributing to death but	not resulting in the	underlying cause g	ven in Part	1.	23e. Did to			the cause of death?
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/ita	ctor.	Be C	25. Was case referred to medical examiner?				26. Plac	e of Death (	Check only o	пе)		
) V	hysio this co al dire	으	1 □ Yes 2 <b>X</b> TXNo	Hospital: 1 ☐ Inpatient		GIIL 3 DOA			e 5 ☐ Resid			Soresidence
Ë	ling F	lon	27. Manner of Death 14. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injun	Wo	ryat ⊮rk? ]Yes 2.⊡		d. Describe h	now injury o	occurred	
Divisio	To the Hospital or Attending Ph within 24 hours after death. To the Funsrel Director: After th completely filled in by the funeral	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	OB Place of Injur	y - At home, larm, (Specify)	street, lactory, office	1 1 1 2 2		If. Location (S City or Tow	Street and t vn, State)	Number or Rur	al Route Number.
_	Hospital 24 hours Funstel stely filled	Medical Co	29a. Certifier 1 Certifying Pl (Check only one) 2 Madical Exe	hysician: To the best of minar: On the basis of e	xamination and/or	ath occurred at the t investigation, in my	ime, date ar opinion, dea	nd place, an ath occurred	d due to the d	cause(s) ar date and pl	nd manner as s lace, and due t	stated. o the cause(s)
	To the Fo the Somple	Me	29b. Signature and title of certifier	^		29c. Licen	se number			29d. Date :	signed (Month,	Day, Year)
	, , , , ,		1 1 7	Lan	WD	D35	535		White sale-random	Sept	13, 20	06
	3		30. Name and address of person who Joseph Kaplan, M		ath (Item 23a) (Typ			nce Ph 20832		rive,	Suite	327, Olney
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	s Signature		, raiiu	20002				
	Registr		SEY 2 0 2000	3	50° / 100°							

State of Maryland / Department of Health and Mental Hygiene 2006 29794 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ELINOR THROUGH ARMACOST September 18, 2006 1:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EDENWALD. Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) June 30, 1 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Yrs. 214-40-4336 96 Director 1910 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road 21286 death v USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ Completed oe filed within 72 hc la! Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Librarian 12 Enoch Pratt Library permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if itsm 27 is marked oth any lighty or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Through 2 Ruth Boyer Stubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James O. Armacost, III 139 Hopkins Road, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 9/20/2006 Baltimore, Maryland 21. Signal Fra ral Subject Consee Mitchell-Wiedefeld Funeral Hone, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approx. Approximate Interval Between Odset and Death Immediate Cause (Final disease or condition resulting in death) Physician unge /Medical solutio disease Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Diseass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b autopsy 1 Yes the Hospitei or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specily) P 2 ER/Outpatient 3 DOA After this funeral dir 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide i 24 hours aft e Funerei Di letely filled in 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check onl) one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SIClar completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who marcelino Moverne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 7:45 PM 2006 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death AGNES HEALTH CARE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 XM 2 ☐ F -39-5112 454-39-5112 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 📉 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry condary (0.12) College (1-4or 5+) ei 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant' Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, thod of Disposition Date 20c. Location € Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee era tricker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory Approximate Interval Between Onset and De and Death Immediate Cause (Final disease or condition resulting in death) 10 How MBOLISM FULMONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 20 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner law requires that the death certificate be executed Box, Ö Δ. Record this certificate has Vital ð or Attending Division death. Director: filled in by To the Hospital of within 24 hours af To the Funeral D completely filled in

**Physician** 

/Medical

Examiner

Director

Funeral

<u>۾</u>

Be Completed

by Physician/Medical Examiner

Be Completed

Certification;

Medicai

29a. Certifier

(Check only one)

**Funeral** 

Director

arment of Health and Mental Hygiene. ortant: if item 27 is marked other then "natural", or iteme 23a or 28a-f show injury or other traumatic event, the Mardical Examinar mant to motified at

permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau

**Physician** 

12 should be f

Maryland 21215-0036

I

State

Registrar

31. Date filed (Month, Day, Year)

SUVARCHALA

29b. Signature and title of certifier

32. Registrar's Signature 5EF 2 U 2000

KOMPELLA, MD

Sw alchala

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ST. AGNES HOSPITAL, BALTIMORE, MD Dente P

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P19923

29d. Date signed (Month, Dey, Year)

SEPTEMBER 14 2006

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Minnie Marie Bathon 3:20 P. M September 2006 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Pasadena 3562 Brickwall Lane If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Sept. 11, 7. Age (In yrs. last birthday) 92 yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Year) 1 M 2 K F 213 50 4149 1914 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County If Itam 27 is marked other than "natural", or Items 23e or 28e-1 show or other traumatic event. The Madical Examinating at Anne Arundel Pasadena 1 Tyes 2 X No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21122 7536 Central Way U.S. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 內 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Iten any injury or other traumatic avant. The Medical Excent 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 →Widowed 4 □ Divorced Year or Dates Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Tolson John Bainer ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Bathon / son 7536 Central Way Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 9/20/2006 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Gonce Funeral Service, P.A. 21. Sig ujure of Funeral Service Licensee 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes To the Hospital or Attanding Physician: Was case examiner? 25. Was case referred to medical 26. Place of Death (Check only one) <del>Caretake</del>r Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 1 Yes 2 No 24 hours after death.

Funaral Diractor: A investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29b. Signature a 29c. License number 10 on who completed cause Print) 30. Name and address no 14 0 32. Registrar's Signature 31. Date filed (Month Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGÍNAL

			For State Registrar	State of M	aryland /		ent of Healt ate of Dea		ntal Hygier		29/98
	Physici	an	1. Decedent's Name (First, Middle, L.		7,10	- T	TT		. Date of Death Month	av Year	3. Time of Death
	/Media	al	SOOKER 1		3RAD		ity, Town, or Local		EPTEMBER	2 14 20 lc. County of Dea	
	Examin	ier	SINA HOSPITAL	-	MOI		BALTIMOR		7		N/A
	Funeral Director		217-50-6708	Sex 7.Ag 1□xxM 2□F	e (In yrs. last 57	birthday) If Un Mont		nder 24 Hrs. 8 urs Min.	Date of Birth (Month, Day, Yea Aug 26, 1		thplace (State or Foreign buntry) <b>Maryland</b>
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
	ith the Marylar or 28a-f ehow	tor	Maryland	N/A			Baltim	nore			1 ☐ Yes 2 ☐ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heelih and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Mudical Examinat must be multiled at	al Director	10e. Street and Number 4721 Amberley Avenu	e		10f.	Zip Code	21229	10g. (	Citizen of What Co	ountry? S.A.
	r deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was De	ecedent of Hispani specify Cuban, Me	ic Origin? (Specit exican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
5-0036	72 hours after death w "natural", or Items 23a	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Wivorced	1 Xes 2 If Yes, Give Year or Dates:	<sup>No</sup> 1967 197	, _ , 0	s 2. DXNo <i>Spe</i>	ecity:		Specify:	Black
5-0	72 ho 'natur	eted	15. Decedent's E (Specify only highest gi	ducation rade completed)		6a. Decedent's L	work done during	most of working	16b.	Kind of Business	/Industry
2121	within ene. then	Completed	Elementary/Secondary (0·12)	College (1-4or	5+)		T use retired) Vlaintenance	Engineer		Coppin S	tate College
	e filed with al Hygiene. other their	Be C	17. Father's Name (First, Middle, Las				18. N	Mother's Name (F	First, Middle, Maide		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the M	To		T. Braddy Jr.						Braddy	
Mar	and 2 sho eelth and I m 27 is mu		19a. Informant's Name/Relationship Hattie Braddy Mother	(Type, Print)	1	-			Route Number, City e, Maryland 2		Zip Code)
Je,	of Heelth of Heelth I Item 27 r other tr		20a. Method of Disposition	Dome of from Chate	20b. Place	of Disposition (	Name of or other place)	Dat	e 20c.	Location - City or	Town, State
Baltimore,	Pa Part T		1 Description 2 Cremation 3 4 Donation 5 Other (Spec	ify)	Garr		Veterans Ce	Siliotory	9/22/06	Owings	Mills, Md.
Bal	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service, Lice	M. 89	Jen	22. Name	and Address of F Estep Broth 1300 Eutav	Facility ners Funera v Place Balt	l Service, P. / imore, Md 21	A. 217	
	Physician /Medical Examiner		23a. Part1. Enter nedisease, or cor shock, or heart allure. List ont Immediate Cause (Final disease or condition resulting in death)	y one cause on each li	ne.		HEMO		espiratory arrest, E  FURMAT,	20 H	Approximate Interval Between Onset and Death 36 HPS
68760,	ficate be executed physicien and st the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as	a consequen	ce of):		70171 0			
P.O. Box 68	law requires that the death certifica as been signed by the attending ph r 2 should be delached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3 □Ectopi	c pregnancy (specify)			23d. Date of de Month	livery Day Year
	w requires that been signed be should be detailed	6	Part II. Other significant conditions  Hyperat	_	ut not resultin	g in the underlyin	ng cause given in F	Part I.			o the cause of death?
of Vital Records,	aw req is been 2 shou	Completed	/-						24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
E E	sician: The law s certificete has t lirector, page 2 s	Com							performed?	death?	
Vita	Physician: r this certificatal director, I	Be	25. Was case referred to medical examiner?	Hospital:			04	Place of Death (6			
ō	Physer this eral direction	n: To	1 Yes 2 No  27. Manner of Death	28a. Date of Inju	ent 2 ER	b. Time of	28c. Injury at Work?		5 Residence d. Describe how in		cify)
sion	Attending F ir death. ector: After by the funera	atio	1 Matural 5 Pending 2 Accident investigate		y rear)	Injury M	1 Yes	2□No			
Division	after de Direct	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place of In	ury - At home c. (Specify)	, farm, street, fac	tory, office	281	f. Location (Street City or Town, Sta	and Number or R ite)	ural Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	ledical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	Physician: To the best miner: On the basis of and manner st	f examination	dge, death occur and/or investiga	red at the time, da tion, in my opinion	ite and place, and , death occurred	d due to the cause at the time, date a	(s) and manner as nd place, and due	s stated. a to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	1			29c. License num			Date signed (Mont	
	. 1		16/wshn fr	menul	touth (lines 22	In Change Bright	DOOL	02808	SE	PTEMBE	R 14, 200
	13		30. Name and address of person who				THE OF	BALTI	MORE		
P	Sta	te	31. Date filed (Month, Day, Year)								

State of Maryland / Department of Health and Mental Hygiene 2 0 0 c

A Contraction			1 - For State Registrar		Ce Ce	rtificate of	Death	P	leg. No.	6 29/9
	Physic /Medi		1. Decedent's Name (First, Middle, Last Harry Frederick I	•				2. Date of Dea Month Sept.	17 2006	3. Time of Death 8:05 a M
	Exami		4a. Facility Name (If not institution, give Carroll Hospital				r Location of Death	1	4c. County of De	eath croll
6 - 9	Funeral Director		5. Social Security Number 6. Se 219-14-8237 15		yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year 9. E	Birthplace (State or Foreign Country) Tyland
Manylood	a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll	10	c. City, Town or L Hampsi					10d. fnside City Limits
Hith Hith	23a or 28	Funeral Director	10e. Street and Number 3100 Snydersburg	Rd.		10f. Zip Code 21074		1	U.S.A.	Country?
C Z I Z I D-UUSO	th and Mental Hygiene. ? Is marked other than "natural", or iteme 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H ff Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, WI Specify: 🎲	
0-0121	ane. than "natur a Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wor d)	king	16b. Kind of Busines	ss/Industry
permit Pages 1 and 2 should be filed within 72 hours of	and Mental Hygiene. Is marked other than aumatic event, tre M	To Be Co	17. Father's Name (First, Middle, Last) Harry Frederick Bo	og	T. G.I.	HUL		ne (First, Middle, e	Dairy Maiden Sumame) Icher	
, Mary	ealth and N n 27 is mar	_	19a. Informant's Name/Relationship (T) Debbie Boog-Sherma	n, daughter	4484	Woodsman	and Number or Ru	ral Route Number	c, City or Town, State	
DICE TO SECOND	If Iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	t. Harks	matory or other place Church	Jem. Sept	. 21,200	20c. Location - City of Snyder	sburg, Md.
	Departmen important: any injury once.		21. Signature of Funeral Service Licens		58	A Name and Addre 296 Charmi	inerally Ch I Dr. Ma	apel P.A nchester	, Md. 211	02
E	hysician and Medical xaminer fransit se the prival-transit	cai Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence of):	enmonia				Interval Between Onset and Death
The law requires that the death certificate be executed	by the sttending ph tached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetaf death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
equires that	been signed by should be deta	by	Part 11. Other significant conditions con Athew sclenchic	ntributing to death but no boronary ve arct. Fran						to the cause of death?  Probably 4 Onknown
		Completed	of the urinar	1. 11		cell ca	rcinoma	24a. Was a autops perform	y prior to	autopsy findings available o completion of cause of as 2 No
Attending Physician:	death. ctor: After this certifical y the funeral director, p	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Activate 5 Pending investigation	dospital: 1 Pinpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time of Injury	of 28c. Injun Work	er: 4 □ Nursing H		el ance 6 Other (Sp ow injury occurred	pecify)
, 6	i Die	i Certification:	3 Suicide 6 Could not be determined	28e. Place of fnjury - building, etc. (S	pecify)			City or Towr		
the Hospital	within 24 hours a To the Funeral I completely filled	Medical	one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated.	y knowledge, deal mination and/or in	vestigation, in my of	pinion, death occur	rred at the time, da	ate and place, and di	ue to the cause(s)
o <sub>T</sub>	n		29b. Signature and title of certifier	200			3453		eptember	18, 2006
1920 Dec	Sta	te.	30. Name and address of person who co	JR, MD  32, Registrar's	Item 23a) (Type,		AVE.	WESTM	INSTEX, M	10 21157
	Registr		SEB o n son			D Town				

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** September BILLIE SNEAD BUDKOFF 16,2006 8:00P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3925 Beech Avenue #209 Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | January 26, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 224-34-0645 84 Kentucky Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at XX Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3925 Beech Avenue #209 21211 Itams 23a USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. snt: if Item 27 is marked other than "natural", or Itams 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **XX**No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Private Foundation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Winston Snead Dona Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Print) Nicholas Alexander Budkoff HUS. 3925 Beech Avenue #209 Baltimore, Maryland 21211 20a. Method of Disposition
1 ADBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. Barvourville Cemetery 9/21/06 4 □ Donation 5 □ Other (Specify) Barbourville Kentucky 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) 110/20 **Physician** werk /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed physicien and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification; To 4 Nursing Home 5 Hesidence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. escribe how injury occurred After 1 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after uses...

To the Funeral Director: # investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D23076 9-18-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Diamond MD 3730 Falls Road Baltimore, Maryland 21211 31. Date filed (Month, Day, Year) 32/Registrar's Signature State JEP 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 29801 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Fae Ralphs Baker September 14, 2006 6:00 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5814 Beech Avenue Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F Hours Yrs. Director 552-68-3575 81 July 18. Idaho Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 5814 Beech Avenue 20817 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 📉 No tf Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 I a marked oth any liury or other traumatic avent 2028. Be Virgil Ole Ralphs Lucinda Mae Corbridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Baker/Husband 5814 Beech Avenue, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 23, 2006 Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Mullian a. M01173 23a. Part1. Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Spinocerebellar Degeneration 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner 6/ the burial-transit physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death signed by the a 5 ☐ Other (specify) ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2X No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performe After this certificete 1 Yes 2 No 1 Yes 2 No luneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation t ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D23556 September 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Robert H. Blee, M.D. 5530 Wisconsin Avenue #1400, Chevy Chase, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SFP 2 0 2006

State of Maryland / Department of Health and Mental Hygiene 2006

29802

			1 - State Registrar		, , , , , , , , , , , , , , , , , , , ,	Cert	ificate of	Death	,	Reg. No.	000	E 2001
	Physic	an	Decedent's Name (First, Middle						2. Date of De		Year	3. Time of Death
	Physici /Medi			lancy Elle		lerki	n	S	EPTEMB		. 2006	6:45 PM
	Examir	ner	4a. Facility Name (If not institution Saint Josep				4b. City, Town, o	Tows	on	4c. Cou	Balt	imore
	Funeral Director		5. Social Security Number 213-58-0457  Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 🕻 F	96 (In yrs. last i	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 1	v. Year)	Cou	place (State or Foreign ntry) ryland
	yland		10a. State 10b. County		10c. City, To	wn or Loca	ation				1	10d. Inside City Limits
	the Mar 28a-f et	Director	Maryland Balti	more	L	uther	ville			10- 64	-4.14/54-0	1 ☐ Yes <b>XX</b> No
	23a or	rai Dir	10 Felton Roa	ıd			21093	3			of What Cour	ntry ?
920	hours after death with the Maryland turet; or Items 23a or 28s-f ehow al Examinar muat be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 <b>X</b> Marr 3 □ Widowed 4 □ Divorced	If Yes Give		lf `	as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, ecify:	
5-0	72	Completed	15. Deceden (Specify only higher	t's Education st grade completed)	16	a. Decede (Give ki	nt's Usual Occup nd of work done	ation during most of wor	king	16b. Kind o	of Business/In	
121	within ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5			ct Coord			Audio	Vicus	1 System
<u>d</u>	Hyg #	0	17. Father's Name (First, Middle,	<del></del>		rroje	CL COOL	18. Mother's Nam	ne (First, Middle			ı system
/lan	71 5 9 0	To B	Benjamir	n Ryland	Pric	e		Marg	aret	Ellen	Isens	see
Maryland 21215-0036	12 sho h and 7 le m traum		19a. Informant's Name/Relations  James Clerki				Address (Street a	and Number or Ru	ral Route Numb erville			
Je,	Heal The the		20a. Method of Disposition		20b. Place	of Disposit	tion (Name of		Date	-	on - City or To	21093 own, State
ij	Pages ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	DuTa	mey"V moria	ailey plac I Garden	s 9-18	-2006	Timo	nium	Maryland
Baltimore,	permit. Pag Department Important: If eny injury o		21. Signature (15) eral Service			22.1		ss of Facility Ru		on Fune	eral Ho	ome, Inc. 1204
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. D						ilu Zi	Approximate
	Physician		Immediate Cause (Final disease or condition	MULTI-		FAT	LURE					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):						
	LXammer	e.	Sequentially list conditions, if any, leading to immediate	b. ATRIAL	_ MYX□ a consequenc							
×	uted d anslt	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				SECTION	N AORTI	C ONEL	DVGM		
) O	exec en and rial-tra		resulting in death) Last	Due to (or as	a consequenc	e of):				K T DPF		
68760,	icate be executed physicien and s the burial-transit	Medicai		d. STATUS	POST	END	OVASCU	AR STE	NT			
9 X	leath certificate be execul attending physicien and I for use as the burial-trar		IF FEMALE:	23c. If yes, outcome	of pregnancy				_	1		
Вох	leath c	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩No	1□Live birth 4□Pregnant at	2 Fetal dea		ctopic pregnancy Other (specify)				Date of delive Month	ery Day Year
Ö.	that the de ned by the a detached t	hysi	9 Unknown	9□ Unknown								
s, P	98 <u>15</u> 98	Ď	Part II. Other significent condition			in the und	erlying cause give	en in Part I.	23e. Did t	obacco use c		ne cause of death?
ord	v requir been si should	Completed	ABDOMINAL AOR	IIC ANEURYSM					10	Yes 2□No	o 3 🗍 Prob	ably 4 Munknown
Rec	nelaw hast ge 2 s	mpje							24a. Was autop		b. Were auto prior to col	psy findings available mpletion of cause of
[a]		ပို	25. Was case referred to medical					00 Pt / P	1 ☐ Yes	2 No	1 🗆 Yes	2) No
Š	Physicien; rthis certific ral director,	To B	examiner?	Hospital: 1 X Inpatie	ent 2 🗆 ER/O	Dutpatient	3□ DOA Othe	26. Place of Dea	th <i>Check only</i> o		Other (Specif	
<u></u>	ng Ph ter thi		27. Manner of Death	28a. Date of Inju		. Time of Injury	28c. Injury Work		28d. Describe I			<i>y)</i>
Sio	Attending r death. sctor: Atte	catic	1 Natural 5 Pendin 2 Accident investig	gation				Yes 2 □No				
Division of Vital Records,	after d Direct	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		ury - At home, c. (Specify)	farm, stree	t, factory, office		28f. Location (S City or Tox	Street and Nu vn, State)	mber or Rura	l Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis of and manner sta	fexamination a	ge, death o	occurred at the tim stigation, in my op	ne, date and place, pinion, death occur	and due to the rred at the time,	cause(s) and date and plac	manner as st	lated. o the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certified	000	. 0		29c. License	number		- marke	gned (Month,	
,	3.1-		Urmano	Lo Co fres	fin			24710		9-1	4-0	6.
	12		30. Name and address of person		<i>y</i>		•					
	Sta	te	ARMANDO ALBO 31. Date filed (Month, Day, Year)	32 Manistr	ar's Signature		OSLER	DRIVE .	TOWSON.	MAR'	YLAND	21204
i.	Registr			2006	as It	for	A					
DH	MH 17 Rev 1/2	001	JEF 6 V	The state of the s								

			1 - For Stata Registrar	State of Maryla	nd / Depa		t of He	ealth an	d Menta	al Hygie		6 2	980
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last,     Robert Louis Cas     Aa. Facility Name (If not institution, give	ey		4b. City.	Town, or i	ocation of D	0 0	te of Death onth	Day Yea 200 4c. County of De	, 6 1:	50 AM
	Funeral Director	ler	Gilchrist Center 5. Social Security Number 6. Sec. 183–38–8438	,	i. last birthday) Yrs.	Tows	son,	Maryla If Under 24	and Hrs. 8. Da Min. (Mo	te of Birth onth, Day, Ye	Baltin ear) 9. E	nore	itate or Foreign
936	within 72 hours after death with the Maryland she.  19.6.  Than "natural", or items 23a or 28a-1 show the Medical Examinar must be notified at	by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo  10e. Street and Number  13427 Fork Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?	Tra Tra	10f. Zip	1013 ent of His rfy Cuban	panic Origin' , Mexican, Pi Specify:	? (Specify Ye uerto Rican,		Citizen of What  U.S.A.  14. Race - At Black, W  Specify:	1 Country?	
N ·	e Hygi other	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)	cation	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us lder	k doné du e retired)	ring most of	Name (First,	Ry Middle, Mai	o. Kind of Busines  ran Homes  den Sumame)	ss/Industry	
Mar	s I and z should be if Health and Mental i item 27 is marked o other traumatic eve	To	Thomas R. Casey  19a. Informant's Name/Relationship (Ty Sharon K. Casey  20a. Method of Disposition	(wife)		7 Fork	k Roa	d Number o		Number, C		1013	ıto.
Baltimore,	permit. Pages I Department of the important: If ite any injury or ot once.		20a. Method of Disposition  1	lemoval from State	cemetery, crer etro Crerr 22	natory or of ptory, 2. Name and	Inc. d Address	09, of Facility I	/19/20 E. F.	06 BA Lassah	altimore In Funera le, Mary	Maryl al Hom	and e, P.A.
E	hysician and //Medical and //M	ical Examiner	23a. Part1. Enter the disease, or complete shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	poxen	ce	ncej	nin		try	Interva	eeks
O. Box 68	fire faw requires that the beant certificate be executed the has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pre					23d. Date of o	lelivery Day	Year
Scords, P	aw requires inat s been signed b 2 should be deta	Completed by Ph	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying ca	iuse giver	in Part I.	-	1 ☐ Yes a. Was an	24b. Were	Probably autopsy find	4 Unknown
VITA	this certificate has ral director, page 2	To Be Com	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 [	7 EB/Outpation	it 3□ DO	Other		Death (Chec		No 1 Y	? es 2□No	of cause of
VISION	ath. r: After	Certification; T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At I building, etc. (Spec	28b. Time of Injury	M 28	Bc. Injury a Work?	4 🗀 Nursin	28d. De	escribe how i	e 6 Øther (Sp njury occurred t and Number or tate)		Number,
_	within 24 hours after de To the Funeral Directo completely filled in by th	Medical Co	29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)  2 Madical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or inv	vestigation,	License	nion, death o  number	ccurred at th	e time, date	and place, and d  Date signed (Mo	nth, Day, Ye	par)
	1241		30. Name and address of person who do	mpleted cause of death (Ite	m 23a) (Type,	Print	)) les S	Sas	eltr.	sund	21 20 )	n 18	12006
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 2	32. Registrar's Sign	ature	Joseph	,						

State of Maryland / Department of Health and Mental Hygieney 29804 1 - For State Registrar Reg. No. Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 15, 2006 Year **Physician** 11: 59PM Horace Mitchell Chandor, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 5009 Dalton Street Temple Hills 8. Date of Birth (Month, Day, Year) July 5,1930 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 🕅 M 2 🗆 F 76 Director 578-40-6434 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Prince George's **Funeral Director** Temple Hills permit. Pages 1 and 2 should be filed within 72 hours after death with tl Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 26 any injury or other traumatic event, If a Mandal Angles of 2000. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Dalton Street 20748 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I ☐ Yes 2 🗓 No f Yes. Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Arthur Chandor Selma Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Chandor (Wife) 5009 Dalton Street Temple HIlls, Maryland 20748 20a. Method of Disposition
11 → Neurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 20, Cedar Eill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry RD Clinton, MD 20735 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 48 /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequency of Examiner physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 🗌 Yes 2 √ No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 PResidence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8 2006 0001923 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C fMD2068 Crain Highway, waldorf, Md. Thomas Fieldson, 32. Registrar's Signature 31. Date filed (Month, Bay State Registrar

			1 - State Registrar	State of M	aryland /	Depa Cer	rtmen <i>tificat</i> e	t of H e of L	ealth a	and M		giene (	20	06	2980	
	Physici		Decedent's Name (First, Middle, Last)  JOHN ALBERT (	CIID ANT							2. Date of Dea Month	ith Day	5	Year 2006	3. Time of Death	1
	/Medic Examin		4a. Facility Name (If not institution, give s UNION MEMORIAL HO	treet and number)				_	Location of		Septem			of Death		
	Funeral Director		5. Social Security Number 6. Sex		e (In yrs. last I	oirthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Sept 2	, Year)	128	Countr	ice (State or Foreigi y) York	n
	Maryland a-f ehow	tor	10a. State 10b. County  Maryland N/A		10c. City, To	wn or Lo								10	d. Inside City Limits	
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow than "Madical Examiner must be notilised at	erai Director	10e. Street and Number 111 Hamlet Hill R	oad, #81		13 V	10f. Zip	,	21210				I	Vhat Countr JSA e - America		
3036	ours after d rral', or item	d by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:		1	Yes, spec		Specify:		cify Yes or No- Rican, etc.)			k, White, et		
Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or liteme 23a or 28a-f show ovent, I've Massical Examinate must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or :	5+)	(Give i life. C	lent's Usua kind of wor DO NOT us Ltor/E	rk done d se retired,	luring mosi )		ng		[nde	siness/Indu epende nools		
yland	should be filed w nd Mental Hygie marked other ti umatic event, III	To Be C	17. Father's Name (First, Middle, Last)  John Girard Coch	ran					Lau	ra E	(First, Middle, nily Ga	iser				
	d 2 stranger		19a. Informant's Name/Relationship (Type Elaine B. Cochran 20a. Method of Disposition	(Wife		.11 H	- Iamle	t Hi	11 Ro	ad,	#812,Ba	1timo	ore,		21210	
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		1 Burial 2 NCremation 3 Re 4 Donation 5 Other (Specify) 21. Signatural Funeual Service Ricepose Martin D. Laws	auson	Green	n Mou	nt Ci Name an tche	rema d Addres 11-W	tory s of Facilit iedef	eld	/2006 _ Funeral	Home	∍, :	Inc.		_
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to for as	cardi a consequenc ON OX	ia\ • of):	ar the mode	int Total	such as	cardiac o	Or Se				Approximate Interval Between Driset and Death Down	
,09/8	cate be executed physicien and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last		a consequence											
C. Box 6	the death certific, y the attending pl ched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	ic. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pro					230	d. Date Mon	e of delivery oth D	ay Year	
rds, P	The law requires that the de ste has been signed by the a page 2 should be detached f	Ď	Part II. Other significant conditions conf	nbuting to death b	ut not resulting	in the un	derlying ca	ause give	n in Part I.		23e. Did to				cause of death?	
al Kecord		Completed									24a. Was a autops perfori	y	pr de	rior to comp eath?	y findings available bletion of cause of No	,
VII	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	ospital:	int 2 ER/O	Outpatient	32 00	A Othe	F		Check only on		Othe	or (Spacific)		
sion of	ling PI	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		. Time of Injury		Bc. Injury Work		2	8d. Describe h					_
DIVISION	To the Hospital or Attenct within 24 hours after death To the Funeral Director: To the Funeral Director: Completely filled in by the teach	l Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	c. (Specify)						8f. Location (Si City or Town	n, State)				
	ne Hos ne Fun sletely t	edical	29a. Certifier  (Check only one)  1 Certifying Physical Certifying Physical Examin	er: On the basis of and manner sta	examination a	ge, death ind/or inv	occurred a estigation,	in my op	e, date and inion, deat	th occurre	d at the time, d	ate and pl	ace, a	nd due to th	ne cause(s)	
	withii To II	ž	29b. Signature and title of certifier					. License		د در	2	9d. Date s	igned	(Month, Da	ay, Year)	_
7	, 0		30. Name and address of person who cor	nolated cause of d	eath (Item 22-	) (Tuna F	1	000	> 3 3	13	Cul	Jepte	Mbe	SC (2	2006	
	7		201 East Universi	4500		_	thing	ore	Mi	> 3	राजा ह		'J'	> (,,	лу, Year) ДОСС	
	Sta Registr		31. Date filed (Month, Day, Year)  SFP 2 0 20	350	ar's Signature	9	and i	p								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 U U 6 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** eatrice 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Parkville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 13,1918 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2₩F Yrs. 88 Director 219-07-9737 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County other traumetic event, the Madical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd. 21234 Items 23e U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ō 1 ☐ Yes 2 ☑ No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Baltimore Museum of Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H John Leon Emerson Abbott Emma Elbert Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Chambliss (Daughter In Law) 901 Drohomer Place Baltimore, Maryland 21210 item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If any injury or once. Green Mount Crematory 9-20-06 Baltimore, Maryland 22. Name and Address of Facility  $Mitchell-Wiedefeld\ F.H.\ Inc.$ 21. Signature of Funeral Service Lic 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or comblications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Frysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of by Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Compieted 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 20 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 🗌 Yes 2 No after death | Director: / d in by the fi 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide pelli thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06 (Type, Pried) 30 Name ... who completed cause of death Name and address of person mentita MU 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar SEP 2 0 2006

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			1 - For State Registrar	State of Ma	aryland		artment of H		nd Mer		ene g. No. 2	006	29807
			Decedent's Name (First, Middle, L.	ast)						Date of Death	1		3. Time of Death
	Physici /Medio		Hettie R. Clif	ford					S	Month eptember	12,	2006	6:35 A M
-	Examir		4a. Fecility Name (If not institution, gr	ve street and number)			4b. City, Town, or	Location of D	Death		4c. Cour	nty of Deat	th
			5708 Stillwell R	oad			Rockville	e			Mont	gomer	У
	Funeral			Sex 7. Age 1 M 2 Age	(In yrs. las	**	If Under 1 Year Months Days	If Under 24 Hours		Date of Birth (Month, Day,	Year)	9. Birt	hplace (State or Foreign
П	Director		216-22-8469	1LIM 2E3F	80	Yrs.				v. 17,	1925		gínia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation						10d. Inside City Limits
	danyl	ō	Maryland Montgom	0.1577	•	ville							1 M Yes 2 □ No
	the 28a-	Director	10e. Street and Number	Ely	ROCK	VITTE	10f. Zip Code			10	g. Citizen o	f What Co	nuntar?
	3a or		5708 Stillwell	Road			20850				nited		•
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin	n? (Specify				nican Indian,
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel", or items 23e or 28e-f ehow atto event. The Medical Examinar must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo		fYes, specify Cuba □ Yes 2💆 No	n, Mexican, P Specify:	Puèrto Rica	in, etc.)		tack, White	
ŏ	2 ho	Completed	15. Decedent's E			16a. Deced	lent's Usual Occupa	ation		1	6b. Kind of	Business/	Industry
2	thin 7	ble	(Specify only highest gi	College (1-4or 5-	+)	life. L	kind of work done o OO NOT use retired	during most of ()	t working				
2	og will	Ю	12			Home	maker				Own	Home	2
g	al Hy d oth	Be (	17. Father's Name (First, Middle, Las	()						rst, Middle, M	aiden Sum	a <i>m</i> e)	
<u>ya</u>	Ment Ment arke	2	Walter Waddell					Mary	Coll	ins			
a	2 sho and iem	1 1	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street a	and Number o	or Rural Ro	ute Number,	City or Tow	m, State, 2	Zip Code)
	end lealth m 27 her tu		Joseph A. Wolfor	d/Son	001 51		Stillwel	and the second second second second	program by the month of	Charles and Control			
altimore,	ges 1 t of H If ite or otl		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	☐Removal from State	20b. Plac	e of Dispo letery, cren	sition (Name of natory or other place	9/	ptelif		Oc. Location	n - City or	Town, State
	Pa tmen tant:		4 ☐ Donation 5 ☐ Other (Spec	**	Monte		Crematoriu	11	16, 20				Maryland
Ba	permit. Pages 1 end 2 should be 1 Department of Health and Mental to Importent: If item 27 le marked of any finury or other traumatic eve ange.		21. Signature of Funeral Service Lice  Wilham A. To		101173	Ro 30	bert A. Pui 0 W. Montgo	inphrey I Omery Av	Funeral venue,	l Home, Rockvil	Rockvi le, Ma	lle, ryl <i>a</i> nd	Inc. 1 20850
П			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	aplications that caused one cause on each lin	the death.	Do not ente	er the mode of dying	g, such as car	rdiac or res	spiratory arres	st,		Approximate Interval Between
I I	Physician	i i	Immediate Cause (Final disease or condition	Cardiac	Arre	st							Onset and Death
	/Medical		resulting in death)	Due to (or as a									
	Examiner		Sequentially list conditions,	<sub>b.</sub> Heart A									
	8 V/8	la la	cause. Enter Underlying Cause (Disease or injury	Due to (or es a		,							
	and -trans	Examiner	that initiated events resulting in death) Last	c. Atheros									10 years
8760,	be ex	E		_Diabete	,	ice oi).							10 years
8/	ficate be executed g physicien and is the burial-transit	dical		d. Diabete	.0								10 years
Box	ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1⊟Live birth 2 4⊟Pregnant at t	2 🗌 Fetal de	eath 3	Ectopic pregnancy Other (specify)				1	ate of deli	ivery Day Year
a. O	at the de by the a stached i	hys	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown									
	igned the	by P	Part II. Other significant conditions	contributing to death bu	t not resultin	ng in the ur	iderlying cause give	en in Part I.		23e. Did toba	cco use co	ntribute to	the cause of death?
ĕ	w require been sig should b	edt	Hypertension, K	nee Osteoar	thrit	is,				1 🗌 Yes	2 🕅 No	3 🗌 Pro	obably 4 Unknown
Hecords,	awre	Completed	Hypercholerster	olemia						24a. Was an	24b	. Were au	topsy findings available completion of cause of
Ĭ	: The law cete has page 2:	E O								autopsy performe 1 Yes 2	ed?	death?	2 No
Vital	ician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?					26. Place of		neck only one			
	Physic this o	၉	1 ☐ Yes 2 📉 No	Hospital: 1   Inpatier				4   Nursii	ng Home	5X Residen	ce 6 □O	ther (Spec	cify)
Ĕ	ng f	ö	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injury Work			Describe how	injury occi	urred	
<u>s</u>	uttendi death. ctor: A y the fu	cat	2 Accident investigate 3 Suicide 6 Could not l					/es 2 □ No					
Division of	tal or Att rs after d el Direct ed in by	Certification:	4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	ry - At nome . (Specify)	a, farm, stre	eet, factory, office		281. 1	Location (Stre City or Town,	et and Nur State)	nber or Ru	ral Route Number,
	To the Hospital o within 24 hours aff To the Funerel Discompletely filled in	edical	29a. Certifier 1\(\tilde{\ti}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}	hysician: To the best of miner: On the basis of and manner stat	examination	edge, death and/or inv	occurred at the tim estigation, in my op	e, date and pointon, death o	place, and o occurred at	due to the cau t the time, dat	se(s) and r e and place	nanner as , and due	stated. to the cause(s)
	To ti To til comp	ž	29b. Signature and title of certifier				29c. License			290	•	-	n, Day, Year)
•			Pu, hl i	y L ~		MY	$D^{3937}$	72			Sep	tembe	r 12, 2006
	01		30. Name and address of person who										
	\		.0				oulevard	West #	#324,	Silve	r Spr	ing,	MD 20901
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0	2006 32. Régistra	rs Signatur		beatto						
		er	JLI & U	CUUU CAR	the A	0° 100							

		1 - For State Registrar	State of Ma	-	epartment Certificate					06	29808
		1. Decedent's Name (First, Middle, Last)			·			2. Date of Dea	th		3. Time of Death
Physi		June Maria	Capece					Month Septemb	er 17,	Year 2006	12:38 A M
/Med Exam		4a. Facility Name (If not institution, give s			4b. City, T	own, or Lo	ocation of Death	DOPCOLL	4c. County		
LAdin		615 Sorrelwood	Court		F	dgewo	foo			Harfo	rđ
Funera	al	5. Social Security Number 6. Sex		e (In yrs. last birth	day) If Under 1	Year I	f Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign
Directo		164-22-7329	M 200 F	76 Y	rs. Months	Days	Hours Min.	(Month, Day Mar. 23			sylvania
ס		Usual Residence of Decedent		70				INCLE Z	<b>,</b> 1000		3y I vanita
rylan how		10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
Ma P-f s	Į,	Maryland Harford		Edgewo	od						1 ☐ Yes 2√2 No
h the	Director	10e. Street and Number			10f. Zip (	Code			log. Citizen of	What Cour	itry?
h wit		615 Sorrelwood Cour	<del>-+</del>		2104	10			USA		
deat	Funeral		Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decede	nt of Hisp	anic Origin? (Spe	cify Yes or No-	14. Rad	ce - Americ	
after or Ita	E C	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 ☐	No			Mexican, Puerto	ricali, etc./		ick, White,	etc.
ours rall,	à	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	י טאנעבן.	Specify:		Specif	w. Whi	te
72 h	Completed	15. Decedent's Educ (Specify only highest grade		16a. (	Decedent's Usual	Occupation	on ina most of worki	ina	16b. Kind of B	usiness/In	dustry
ithin ith	l a	Elementary/Secondary (0-12)	College (1-4or 5	i+) '	(Give kind of work life. DO NOT use	retired)					
ed w ygier t, th	Ö	12		New	Account				Bank		
tal H d oth	Be	17. Father's Name (First, Middle, Last)				18	8. Mother's Name	(First, Middle,	Maiden Sumar	ne)	
Men Men arka	P	Harry (nmn) Churc	:h					(nmn) K			
Should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other then "natural", or Itams 23a or 28a-f show reumetic event, II're Medical Eventier from the retitined at		19a. Informant's Name/Relationship (Typ			Mailing Address (						
and ealth T 27		Robert E. Capece/ H	lusband		15 Sorre			-		-	
of H of H		20a. Method of Disposition 1 ☐ Burial 3☐ Cremation 3 ☐ Re	emoval from State	20b. Place of I	Disposition (Name , crematory or oth	e of ner place)		Date	20c. Location	- City or To	wn, State
Pages ment of t ant: If its ury or o		`4 ☐ Donation 5 ☐ Other (Specify)		Hilltop	Service	Cor	p. 9-19	0-06 I	owson,	Mary	land
permit. Pages 1 and 25 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene; in Department of Health and Mental Hygiene; in Italians 23a or 28a-f show any injury or other treumatic event, the Medical Eventivet must be notified at	ODC	21. Signature of Funeral Service License	е				éfally Hom				
8962	a	Manuel a m	uges		1317 C	kesb	ury Rd.,	Abingd	on, Man	cyland	1 21009
icate be executed physician and sthe burial-transit	•	resulting in death)  Sequentially list conditions, It any, leading to manufata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of a nonsequence of a consequence of	Dr.						
death certifi of attending fed tor use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death	3 ⊟Ectopic pre 5 □ Other (spe				1	ate of delive	ory Day Year
tw requires that the s been signed by the should be detach	à	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the underlying ca	use given	in Part I.	23e. Did to		_	ne cause of death? ably 4 Unknown
icien: The law re certificate has be rector, page 2 sho	Completed							24a. Was a autops perform	ned?	Were autoprior to condeath?	psy findings available npletion of cause of
icien: sertifica ector, p	Be	25. Was case referred to medical examiner?				2	6. Place of Death				
nysic nis ce direc	To E	1 Tyes 2 No	ospital: 1 🔲 Inpatie	nt 2 ER/Outp	patient 3 DOA	Other:	4 Nursing Ho	me 5 Reside	ence 6 Oth	ner (Specify	1)
To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Diractor: Atter this certificate hi completely filled in by the funeral director, page	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	Yea <i>r)</i> Inj	M M		s 2□No	28d. Describe h			l Route Number,
pital or A urs atter sref Dirac		4 Homicide determined	building, etc					City or Tow	n, State)		
To the Hospital or Attendi within 24 hours after death. To the Funerel Diractor: A completely filled in by the fu	Medical	29a. Certifier (Check only) one)  20b. Signature and title of certifier	er: On the basis of and manner sta	examination and	or investigation, i	n my opini	ion, death occurr	ed at the time, d	ate and place,	and due to	the cause(s)
To To		29b. Signature and title of certifier	m	· Q.	290.	License n	220N	Q.	9d. Date signe	a (Month, I	Q Dem
		1				27	10		TOU CANO	ECY (	2,000
0		AD. Name and address of person who con	mpleted cause of de	eath (Item 23a)	ype, Print)	l Ri	the box	200,1	ster Ai	2,0	2014
∂ S Regis	State strar	31. Date filed (Month, Day, Year) SEP 2 0 200	32 Hegistra	ar's Signature	Spelle						

			For State Registrar		State	of Mar	yland	/ Depa	rtment of F	lealth Deat	n and M th	lental H	lygier Reg.	1e <sub>No.</sub> 20	06	29809
	Dhoolei		1. Decedent's Name (Fin	st, Middle, Las	st)							2. Date of Month		Day	Year	3. Time of Death
	Physici: /Medic		Adelaid	de Arc	cher C	cale						Septer			2006	3:20 A M
	Examin		4a. Facility Name (If not	institution, give	e street and nu	umber)			4b. City, Town, o	or Locatio	on of Death	-		4c. County	of Death	
			Madonna I						Jarrett					Harf		
	Funeral		5. Social Security Number		ex □M 2. <b>3</b> XF	7. Age (		st birthday) Yrs.	If Under 1 Year Months Days	Hour	der 24 Hrs. S Min.	8. Date of (Month,	Day, Ye	ar)	Cou	
	Director		213-36-8451 Usual Residence of Deci				88	115.				Oct.	29,	1917	Mar	yland
	and wo			. County		1	0c. City,	Town or Lo	cation							10d. Inside City Limits
	f ehc led	0	Maryland H	arford		1	Bel Z	Air								1 ☐ Yes 2 No
	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street and Number						10f. Zip Code				10g.	Citizen of V	What Cou	ntry?
	3a or		1334 Somerv	:11a D	3				21015				US	70		
	death ms 2	Funeral	11. Marital Status	TTTG I	12. Was Dec		er in U.S.	. 13. V	Vas Decedent of H	lispanic	Origin? (Spe	ecify Yes or		14. Rac		can Indian,
9	or ite	Ē	1 Never Married	2 Married	Armed F	2 No			Yes, specify Cubi			Hican, etc.)			ck, White,	etc.
<u>8</u>	hours after death with the Maryland turel; or Items 23a or 28a-f ehow at Examiner outst be multiled at	by	3€ Widowed 4 □	Divorced	If Yes, G Year or I	Dates:			I□Yes <b>2</b> ☐ No	Spec	y:			Specify	Whit	e
21215-0036	27	Completed		Decedent's Ed	ducation de completed	()		(Give	lent's Usual Occup	during n	nost of work	ing	16b	. Kind of B	usiness/In	dustry
2	within one one.  than "	n pf	Elementary/Secondary	- 1		(1-4or 5+)		lite. L	DO NOT use retire	d)			_	1.73	G - 1	- 7
2	e filed w al Hygier other th		11					Teacr	ner's Aid	-		/5 - A Mid		blic		01
<u>n</u>	be fill	Be	17. Father's Name (First,		_							(First, Mide			10)	
3	should be to marked o marked o	2	Francis Tr					405 11-77-	= Add /04:5-4			izabe	-		Oteste Wi	- 0- 1-1
Maryland	2 2 20 20		19a. Informant's Name/F						g Address (Street					•		
d)	1 and Health em 27 thar tr		Edward A. C	<u>_</u>	son	1	20h Pla		Somervil	тте і		SEL AL		Location -		
Baltimore,	if ite		1 🔀 Burial 2 □ Cre	emation 3			cen	netery, cren	natory or other pla		1					
Ħ	rtmer rtant		° 4 □Donation 5 □			{	Cent:		M. Churc		9-19-	-06	_Fc	rest	Hill	, Maryland
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot once		21. Signature of Funera	2//	msi	_	_	Î	Name and Addre McComas E 0 W. Bro	une badwa	ral Ho ay, Be	me P	; ∰a	rylar	nd 21	014
			23a. Part1. Enter the dis shock, or heart fail	sease, or com ure. List only	plications that one cause on	caused the	e death.	Do not ente	er the mode of dyir	ng, such	as cardiac o	or respirator	y arrest,			Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition		An	· resi	0-									Onset and Death
	/Medical		resulting in death)		Due to	o (or as a o	conseque	nce of):								
	Examiner		Sequentially list condition	ens.	D	nent										4000
	p #	iner	cause. Enter Underlying	late.	D113 10	(or as a c	tonseque	nna of):								
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last		C.	. /									-	
60,	cian a	Ē	, , , , , , , , , , , , , , , , , , ,		Due to	o (or as a o	onseque	ince oi).								
68760,	icate be executed physician and s the burial-transit	dlcai			d								-		-	
9 x			IF FEMALE:		23c. If yes, or	utcome of	pregnanc	rv.				11111111111111111111111111111111111111		004 Da		
Вох	death certif e attending ad for use as	Physiclan/M	23b. Was decedent preg in the past 12 month	ths?	1 Live	birth 2	Fetal d	leath 3	Ectopic pregnancy Other (specify)	у				1	te of deliv Inth	Day Year
	D 00 0	ysic	1 ☐ Yes 2 No 9 ☐ Unknown		9□ Unki		ile oi dea	J_	Cities (specify) _	_			-			
P.0	de de		Part II. Other significant	t conditions	contributing to	death but	not result	ing in the ur	nderlying cause giv	ven in Pa	art I.	23e. D	id tobacc	o use cont	ribute to t	he cause of death?
ds,	sign sign d be	d by	Shoke									1[	Yes	2 <b>N</b> 0	3 🗌 Prol	oably 4 🗆 Unknown
Record	w requir been si should	Completed	1+77									24a. W	as an	24b 1	Ware auto	ppsy findings available
3e	The lay	ш	1) //						·····			au	itopsy informęd	! !	prior to co death?	impletion of cause of
a			05.14									1 TYe	s 2/A		1 🗌 Yes	2 □ No
Vital		o Be	25. Was case referred to examiner?	o medical	Hospital:	71	205		Ott	hor:		(Check on		2 (7)	(2	
of	Phys rat di	H :	1 ☐ Yes 2 ☑ No 27. Manner of Death		1	Inpatient of Injury		R/Outpatien !8b. Time of	1 3 DOA	4 🗆		me 5 ∐ He 28d. Descrit		-	_	ty) 1258, steel liver
	Attending I or death. actor: After by the funer	tlon	1.0	Pending		e of Injury onth, Day Y	'ear)	Injury	28c. Injui	rk? ]Yes 2				,,		
Division	Attendi death. ctor: A y the fu	flca	3 ☐ Suicide 6	Could not b		ce of Injury	- At hom	ne, farm, str	eet, factory, office						er or Run	al Route Number,
Ö	after Olra	Certification:	4  Homicide	determined	buile	ding, etc.	(Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or	Town, Si	ate)		
_	Hospital or Attendi 24 hours after death. Funeral Diractor: A etely filled in by the fi		29a. Certifier 1	Certifying Ph	nysician: To th	ne best of (	my knowi	ledge, death	occurred at the ti	me, date	and place,	and due to t	he cause	e(s) and ma	anner as s	tated.
	e Ho 124 h e Fu letely	edical	(Check only 2 one)	Medical Exar	niner: On the and ma	basis of ex inner state	xaminatio d.	on and/or inv	vestigation, in my o	opinion, o	death occurr	ed at the tim	ie, date	and place,	and due t	o the cause(s)
	To the Hos within 24 hc To the Functional Completely	Me	29b. Signature and title	of certifier					29c. Licens	se numb	er		29d.	Date signe	d (Month,	Day, Year)
			Wan.	& K	les	mo			Di	3129	5			9/18	106	
	†			0		use of dea	th (Item 2	23a) (Type,					1			
4	5		30. Name and address of the second se	10852	6401	16 C	heze	15 St	Sute 4	20/	850	ut n	nd	2100	26	
	Sta	te	31. Date filed (Month, Q	E D O O	2006 32.	Registrar	s Signatu	reas	Sosale D							
	Registi	ar	31	LIAU	2000		Fred d	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 18, 2006 deCHEUBEL GREENWOOD 6:09 a M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard Columbia 6050 Waterloo Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) \_ 8. Date of Birth (Month, Day, Y July 16, 7. Age (In yrs. last birthday) 5. Social Security Number Days 1 M 2 F Maryland 69 219-26-1332 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 6050 Waterloo Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1XXYes 2 No 1955-1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12 College (1-4or 5+) Automobile Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah James Hugo deCheubel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6050 Waterloo Road Columbia, Maryland Thelma deCheubel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 Cremation 3 Removal from State 9/21/2006 Marriotsville, MD Crest Lawn Mem. Pk. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. 43 / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) l year Multiple Myeloma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 🔯 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes XX No 2**X**No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home \*\* Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2XXVo 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suscide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 23601 September 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this certificete has al director, page 2: After To the Front after death.

To the Funeral Director: After the funeral by the fune To the Hospital

**Physician** 

/Medical

Examiner

Funeral

Director

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene.
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**Physician** 

/Medical

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Examiner

by Physician/Medical

Completed

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Certification:

Medical

Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year) 2006

Edward J. Lee, M.D.

32 Registrar's Signature

11065 Little Patuxent Parkway

Columbia, MD

			For State Registrar	State	of Mary	land / Depa <i>Cei</i>	artmer <i>rtifica</i>	nt of H te of L	ealth D <i>eath</i>	and M	1ental Hy	giene Reg. No	200	6 29811
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with	30 0	Ö	2636 Yorkway				21	222				T.	JSA	
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ITIU K I K I STOOOO  be filed within 72 hours after death with the Maryland ital Hygiene.	if item 27 is marked other then "naturel", or itema 23a or 28a-1 show or other traumatic event, the Madical Examiner must be nutified at	by Funeral I	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F 1 Tes If Yes, G Year or I	2 XNo		lf Yes, sp 1 ☐ Yes	v	Specify		Rican, etc.)		Specify: W	
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DEMILITION Permit. Pages Department of	inju		21. Signature of Funeral Service Lice	nsee					ss of Fac	ilin <b>B</b> ra	dley-			neral Home,
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death certific	endir r use	ar.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o 1□Live			∃Ectopic	pregnancy	,				23d. Date of o	
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DIVISION For Attending	from Funerei Director; Affer this certificate has been si completely filled in by the funeral director, page 2 should I	Certification:	3 Suicide 6 Could not determine	4 206. Plas	ce of Injury - ding, etc. (S	At home, farm, st Specify)	reet, facto	ory, office				(Street a		Rural Route Number,
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	X		30. Name and address of person who	completed ca	use of death	(Item 23a) (Type	Print)			٠, ر			1	200
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State of Maryland / Department of Health and Mental Hygiene 200629812 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Davis 1:51 AM Sept ID 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner George's Hospital Center Chererly MD
If Under 1 Year | If Under 24 Hrs. rince 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) , Funeral Days Hours Min 1□M 25 F 250-58-9552 Jefferson City SC Yrs. Director June 21, 1939 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or itsms 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No by Funeral Director andover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road 20785 U-5-A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itsm 27 is marked other than "ne sny injury or other traumatic event, Its Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Agent 12 yv D. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Truesdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9505 Wanda V. Clinton MD 20735 Ave 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cem. Washington 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 5732 Georgia Ave. State Washington 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death FATAL CARDIAC ARRHYTHMIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 XÚnknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? was an autopsy performed?
Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year, 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY HOSPITAL LITTLE 3001 3 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ralph De Campo Sept 14, 2006 2:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pineview Nursing Home Prince George's Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Min. Months Davs Hours Yrs 577 32 6548 79 Director June 8, 1927 New York Usual Residence of Decedent 10c. City, Town or Location wode 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28s-f show other treumstic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Clinton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9106 Pineview Lane 20735 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 □ No Korean If res, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. XX Never Married 2 Married 1 ☐ Yes 2 ☐ Ne Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: if Item 27 is marked other th
eny injury or other treumatic accert Sign Painter Self- Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph De Campo Mary Falico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9167 Windsor Drive, King George, Va 22485 Margaret D. Heath (Sister) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Sept 18, 2006 Cheltenham, Maryland 21. Signature of Funeral Service Landsee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 moo257 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOVASCULAR DUSALE TEAMS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, seating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the attending physicien and hed for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident npletely filled in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Momicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-18545 SEPTEMBER 18, 2006 WY of person who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky ,MD 12070 Old Line Center, Waldorf, Md.20601 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar SEP 2 0 2006

Please Type or Print in Black Indelible Ink Bridget M. Ewachiw State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Y September 15, 2006 Medical Examiner 0730 hrs Bridget Ewachiw 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Baltimore County** St. Joseph Medical Center Towson 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Director CouMarvland 2005 213-73-9135 1 M 2 XF June 12. Usual Residence of Decedent 10a State I0c. City, Town or Location 10d, Inside City Limits any Yes 2 X No 28a-f show Baltimore MD Baltimore items 23a or 28a-f sho ist be notified at once. death with the Maryland Director 10e Street and Number 10f. Zip Code 10a, Citizen of What Country 215 Regester Avenue 21212 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. 1 XNever Married 2 Married Armed Forces? White, etc. 2X No Yes White If Yes, Give Year Widowed Divorced 1 Yes 2 X No specify. Specify permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. þ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Not employed N/a n/a 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ewachiw Patricia Cannon Be Eugene Alexander 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene A. Ewachiw-father 215 Regester Avenue, Baltimore, MD 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley 9/20/06 Timonium, MD 4 Donation 5 Other Specify. Dau 22 Name and Address of FacilityRuck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee Jilliam Towson, MD 21204 1050 York Rd., 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure List only one cause on each line hypoplasia /Medical Death Sudden unexplained death in childhood with adrenal hupoplasia Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical #23a,perME, G #23a,27,perME, G862 X UNPENDED X AMENDED attending physician or use as the burial g862. 27/06 Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c Injury at Work? 28d Describe how injury occurred Certification: 1 XNatural 1 Yes 2 No 5 Pending 24 hours after death Funeral Director: the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within 7 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E September 16, 2006

OCME 2006

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2006 0

Assistant Medical Examiner

Registrar's Signature

Ana Rubio MD.

31. Date filed (Month, Day, Year,

SEP 2

			1 - For Amend item#26,1	State of perMD,g859	Marylar ,9/20/00	nd / Depa TT Cer	artmen rtificat	nt of H	ealth a Death	ind M	ental Hyg	iene	2006	298	15
	Physici /Medic		Decedent's Name (First, Middle, Last     CLAUDETTE FAYE	•							2. Date of Dea	th	8, 2006	3. Time of De	ath
<b>)</b>	Examir		4a. Facility Name (If not institution, give SINAI HOSPITAL		per)		4b. City,		Location o	Ξ		4c.	County of Death		
城	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217–40–6735 1 M 2 F 61 Yrs.						Hours	Min.	8. Date of Birth (Month, Day 6-11-	1 <sup>°</sup> 94 <sup>°</sup> 5	9. Birth MAR	pplace (State or Fo	oreign
	Maryland	or	Usual Residence of Decedent  10a. State 10b. County  MD • N/A			ty, Town or Lo									
	with the Na or 28e-	Director	10e. Street and Number 3706 FERNHILL	RD.		DALITIN	10f. Zip	Code 2121.	5		1	_	•		
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? XNo	'		dent of Hi city Cubar		gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	MARYLAND    10d. Inside City Lim   1			
21215-0036	filed within 72 ho Hygiene. other than "natur ent, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) —12—	life. I		rk done a	urina most	of workin	g						
Maryland	2 should be filed and Mental Hygi is marked other eumatic event, II	To Be	17. Father's Name (First, Middle, Last)  18. Mother's								(First, Middle, I	Sumame)			
	1 and 2 sh Health and Iem 27 is m		JAMES EVANS (H	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  JAMES EVANS (HUSBAND)  3706 FERNHILL RD. BALTIMORE, MARYLAND 21215											
Baltimore,	Party		20a. Method of Disposition  1 Paurial 2 Cremation 5 Dother (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  ARBUTUS MEMORIAL PARK 9-15-2006 BALTIMORE, MARYLAND												
Ball	permit. Departm imports any inju	21. Signature of Fundral Sprice Licensee JONATHAN D. HIBNER Name and Address of Facility REDI										'IMO		YLAND 21:	217
	Physician /Medical		shock, or Heart failure. List only one cause on each line.												
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause, Disease or injury  The position of the conditions of the condition												
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last		as a conseq										
P.O. Box 68	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pr					2						
Ś	quires that n signed b	d by P	Part II. Other significant conditions co	ontributing to dea	th but not res	ulting in the ur	nderlying c	ause give	n in Part I.		W		_		
Division of Vital Record	: The law requir cate has been s page 2 should	Completed by	Cigarette Snollin	9								y ned?	prior to co	ompletion of cause	ilable e of
<u> </u>	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 N Yes 2 □ No	Hospital:		50.0	- <del>M</del>	Othe	-		(Check only on			,	
ion of	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		8c. Injury Work	4 🗆 1401		A			fy)	
Divis	tel or Atters after de Binecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At ho , etc. (Specify	ome, farm, stre y)	eet, factory	, office		21	Bf. Location (St. City or Town		reet and Number or Rural Route Number, , State)		
	To the Hospitel or within 24 hours afte To the Funerel Directional Completely filled in I	edical	29a. Certifier 1 ✓ Certifying Phy (Check only 2 ☐ Medical Exam	ysician: To the b liner: On the bas and manne	is of examina	wiedge, death tion and/or inv	occurred restigation	at the tim , in my op	e, date and inion, death	l place, ar h occurre	nd due to lhe ca d at the time, da	use(s) a ate and	and manner as s place, and due t	stated. o the cause(s)	
)	To the within 3 To the comple	Σ	29b. Signature and tille of certifier  Clan beflow		29c. License number 93 7035					29d. Date signed (Month, Day, 1)					
	13		30. Name and address of person who of Clan Lefkourt	2,5400	ord				de 20	5,0	andall!	ulstown, 17d. 21133			
*	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 2	006 32. R.S.	istrar's Signa	ture	porte	B							

State of Maryland / Department of Health and Mental Hygiene 2 29816 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15 **Physician** James Fesmire, Jr. Μ. September 2006 5:25 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 15, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□XM 2□ F Mary land 217-18-0417 85 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or Items 23a or 28e-f ehow vent, the Macdical Examinar must be notified at Md. Baltimore Lutherville Funeral Director 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12240 Roundwood Rd. Apt.801 21093 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed permit. Pages 1 and 2 should be filed v
Depertment of Health and Mental Hygie.
Important: If Item 27 is marked other ti
eny Injury or other treumatic event, the Tug Boat Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James M. Fesmire, Sr. Sophia T. Radavich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Lou Fesmire/ Wife 12240 Roundwood Rd. Lutherville, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 9-19-06 Timonium, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Aneral Fervice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsei and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SHOCK CARDIOGENIC hour /Medical Due to (or as a consequence of) Examiner MYECARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit OROUARY physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ete hes been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Onknown Completed 1 TYes 2 No. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 1 1 1 0 : After this certification at the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 2 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation within 24 hours efter der To the Funersi Directo completely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) andle c D0032338 221 30. Name and address of a son who co pleted cause of death (Item 23a) (Type, Print) SCHECHTER ONALD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

			1 - State Registrar	State of Maryla	Cei	tificate of	Death	Reg. I							
. 8	Physici	100	1. Decedent's Name (First, Middle, La	FRANC	21:			Date of Death Month	Day Year . 17 , 200	3. Time of Death					
	/Medic Examin		4a. Fecility Name (If not institution, given MANOLCALE)	re street and number)  ROSSVILL	E	4b. City, Town, o Baltimore	r Location of Death County		4c. County of Death Baltimore	1					
Ī	Funeral Director			Sex 1□M 2√XF 85	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min. A	Date of Birth Month, 6a192	9. Birth Balti	nplace (State or Foreign Maryland					
	land		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits					
	the Marylar 28e-f show	ctor	Maryland Harford		Bel Air					1 ☐ Yes 2 💢 No					
	ath with th	ral Director	10e. Street and Number 2025 Crocker Drive			10f. Zip Code 21014		1	Citizen of What Cor	untry?					
9036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or Iteme 23e or 28e-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Specifian, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.					
15-(	n 72 h "netu edical	letec	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	16b.	. Kind of Business/I	ndustry					
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Maryland 21215-0036	should be filed nd Mental Hygin marked other imatic event, II	To Be C	17. Father's Name <i>(First, Middle, Last</i> Stephen Rosasco	irst, Middle, Maiden Sumame)											
	is 1 and 2 should be filed of Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship ( Georgia J Shannahan	(Daughter in Law)	PO Box	b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 63 Tilghman Island, Maryland 21676									
Baltimore,	90 = 5		20a. Method of Disposition  ★★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	THemoval from State		sition (Name of natory or other pla metery Se	ptember 20 200		20c. Location - City or Town, State Baltimore, Maryland						
3alti	permit. Pa Departmer Important eny injury		21. Signature of Funeral Service Lice	. / \0	/ 110	. Name and Addre	mal Home Tree								
	40200		23a. Part1. Enter the disease, or com	plications that caused the de	ath. Do not ente	101 Belair er the mode of dyi	Road Baltimore	e, Marylary	d 21236	Approximate					
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  SQUAMOUS CELL CANCER LEFT SUBMANDIBULAR AREA  Interval Between Onset and Death												
	Examiner			Due to (or as a cons	equence of):										
9	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):					-					
h	execute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):										
68760,	tificate be executed g physician and as the burial-transit	edicai	(	≤ d											
	certific Iding p		IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of deli	2004					
P.O. Box	ttending Physician: The law requires that the death cert death. stor: After this certificate has been signed by the attendin the funeral director, page 2 should be detached for use.	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	у		Month	Day Year							
	es that gned b	by Pt	Part II. Other significent conditions		esulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?					
ord	w requires the been signer should be considered.		DEN	DENTIA						bably 4 🗝 nknown					
Vital Records,	The law cate has t	Completed						24a. Was an autopsy performed? 1 Yes 2	?   death?	opsy findings available ompletion of cause of					
Vita	ding Physician: h. After this certifica funeral director, p	Be	25. Was case referred to medical examiner?	Hospital:		. aCL DOA Ott	26. Place of Death (C								
of	g Physier this	n: To	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	28c. Inju	y at 28d	5 Residence  I. Describe how in		ify)					
sion	tending death. tor: Aft the fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n	Injury	M 1	Yes 2 □No								
Division of	ne Hoepital or Attendi 124 hours after death. Ne Funeral Director: A Metely filled in by the t	Certification	3 Suicide 6 Could not be determined		home, farm, streetfy)	eet, factory, office	28f.	Location (Street City or Town, Sta	and Number or Rui ate)	ral Route Number,					
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	To the l within 2 To the I complet	Σ	29b. Signature and title of certifier  A	wnd, MD		29c. Licens	061789	29d. C SEA	Date signed (Month	17, 2006.					
	D		30. Name and address of person who LORFAINE OFTE	completed cause of death (It	em 23a) (Type, PHILADE	Print)									
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig					,						
		-	SEP Z U	LUUD James	30										

		•	For State Registrar		5	State of I	Marylar	nd / Depa <i>Ce</i>	artme <i>rtifica</i>	nt of H	ealth a D <i>eath</i>	and Me	ental Hyg R	jiene 4 leg. No.	2006	5 6	29818	
	Dhycini	_	1. Decedent's Name (/	First, Middle	, Last)							2	2. Date of Dea Month	th Day	Year	3.	Time of Death	
	Physicia /Medic	al -	Pearl			Ε.			Gek				Septe	1:00A 4c. County of Death				
	Examin	er	4a. Facility Name (If no							y, Town, or 1 <b>+ i</b> mon		f Death		4c. C				
	Funeral		Johns Hop  5. Social Security Num		- Bay 6. Sex			last birthday)	If Und	ltimo:	If Under a	24 Hrs. 8	3. Date of Birth (Month, Day	1	N/A 9. Bir	thplace (	(State or Foreign	
	Director		219-52-05	94	1 □ №	2½F	56	Yrs.	Month	s Days	Hours	Min.	ecember	23,19	49 Baî	timo	ore, MD.	
	and **	-	Usual Residence of De 10a. State	ecedent 0b. County			10c. Ci	ty, Town or Lo	ocation							10d. In	side City Limits	
	Maryl -f sho	ţō	Maryland	N	/A			Baltim	ore								XYes 2 □ No	
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920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show apprintury or other traumatic event, the Madical Examinar must be notified at angle.	by Fur	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 [			. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	os? Č∏No			cedent of His secify Cubar 2 XNo	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		Black, White Processing Specify:		·	
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ılan	Aental Aental rked tic ev	ToB	Richard Shingler Ruth Funkouser															
lary	2 sho and h is me	•	19a. Informant's Name/Relationship (Type, Print)  Roseann MacDonald Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City 3228 Eastern Avenue, Baltimore, 20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c.										-					
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nor	20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City   20c. Locat										•							
Baltimore,	permit. P Departme Importan any injur		21. Signature of Fune			0 (	20.00	00 8	2. Name	and Addres	s of Facility	yl Hon	me Of D Road, D	unda	lk,P.A		222	
			23a. Part1. Enter the shock, or heart for	disease, or	complica	tions that cau	sed the dea								IN, PIU	Appi	roximate val Between	
	Physician /Medical Examiner		Immediate Cause (Findisease or condition resulting in death)		gii, die		as a conse	bu	PIL	MICE	4	O.B.	5 600	T	100	Ons	et and Death	
8760, <sup>A</sup>	ficate be executed physicien and is the burial-transit	dicai Examiner	Sequentially list condi- if any, leading to immicause. Enter Underly Cause (Disease or inji- that imitated events resulting in death) Las	ing ury	c	4	as a consec	ah	(	AN	CE	R	<u> </u>		<i></i>			
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	ding Physician: The law requires that h. h. After this cartificate has been signed b funeral director, page 2 should be deti	þ	Part II. Other significa	ant condition	ons contri	buting to deat	h but not re	sulting in the u	ınderlyin	g cause give	n in Part I.			bacco use			use of death?	
000	s beer 2 shou	24a. Was an autopsy finding prior to completion of death?  1 Yes 2 No 1 Yes 2 No 1 Yes 2 No										ndings available						
Ä	The late hapage																	
/ita	cian: ertific ector,	Be	25. Was case referred examiner?	d to medical								of Death (	Check only or	10)				
of o	Physic this c	2	1 Yes 2 No	<u> </u>		spital: 1 ☐ Inp		ER/Outpatie			4 🗆 190		e 5 🗆 Resid			ecify)		
O	ding th. After funer	tion		5 Pendin		28a. Date of I (Month,	Day Year)	Injury	M	28c. Injury Work	:?` ∕es 2 🗀 I		id. Describe in	ow injury	occurred			
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	27. Manner of Death 1 Shatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred										ite Number,						
	Hospi 24 hou Funer Funer tely fill	Medical				r: On the basi	s of examin						nd due to the o				cause(s)	
	ithin 2 o the	Mec	29b. Signature and in	le o certifie	r	and manner	stated.			29c. License	number		2	9d. Date	signed (Mon	th, Day,	Year)	
	~ × → ö	A .	1//	10	2	PS				1) 1	57	3 V		epte	imber.	20,	2006	
	3		30. Name and address	Bala	who com	pleted cause	of death (Ite	m 23a) (Type,	Print)	Eas	tem	1	+. Bo	en.	mere	pers	2006	
	Sta Registr		31. Date filed (Month.		0 200	199	istrar's Sign	ature	Carl	2							, , , , ,	

			1 - For State Registrar	e of Maryland /		ent of Healt ate of Dea			ene 200	6 29819
Ħ	Physici /Media		Decedent's Name (First, Middle, Last)     Man	ian Elizabe	th Hilt	ner		Date of Death Month PTEMB	Day Yeer	3. Time of Death
)	Examir Funeral Director		4a. Facility Name (If not institution, give street and 24 Chalmers Avenue  5. Social Security Number 6. Sex 1 M 203	7. Age (In yrs. last	birthday) If U	City, Town, or Locat G1en Buri nder 1 Year   II Ur ths   Days   Hou	nie nder 24 Hrs. 8. r	Date of Birth Month, Day, Y	rear)C	
	υ υ	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arunde.	10c. City, To	own or Location		110	19 10,	1)25	10d. Inside City Limits 1 Yes 2 No
	death with the Maryland ime 23a or 28a-f ehow ritiost be notified at	al Director	10e. Street and Number 24 Chalmers Avenue		10	Zip Code 21061		100	g. Citizen of What C	ountry?
036	ours after of, or its	i by Funeral	1 Never Married 2 Married 1 1 1/1	Decedent Ever in U.S. ad Forces? Yes 2 M No s, Give or Dates:		ecedent of Hispanic specify Cuban, Meres 2 No Spe		Yes or No- n, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
21215-0036	withir ene. then	Completed	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0·12)  8th  Colle	oted) 16 oge (1-4or 5+)	(Give kind o life. DO N	Usual Occupation of work done during OT use retired) e Operato:	•	16	Factory	·
Maryland	d be ental ked c	To Be C	17. Father's Name (First, Middle, Last)  Raymond D:				Mary Th	nomas		
	iges 1 and 2 shou not be the alth and M if item 27 ie mar or other treumati		John Hiltner / son  20a. Method of Disposition	6		nson Land:		everna	City or Town, State, Park, Mar Oc. Location - City or	yland 21146
Baltimore,	P. D. P.		1 Suburial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	from State Ceme	r Hill	or other place) Cemetery  ne and Address of F	9/19/20	006 B	altimore,	Maryland
Ba	permit. Departr Importa		23a. Fart1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. D	4001	Ritchie	Highway	Balti	<u> </u>	yland 21225
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	on each line.  Ocute le to (or as a consequence		eardia				Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Corco va	ry (	frtory	DIO	oche	mulitires	
8760,	ate be executed obysicien and the burial-transit	I Examiner	that initiated events c.	e to (or as a consequence	R MOLO	9N	<u> </u>			
O. Box 687	ath certificate ttending phys or use as the	Physician/Medical	in the past 12 months?	s, outcome of pregnancy ive birth 2 ☐ Fetel de: Pregnant at time of death Unknown	ath 3 ⊟Ecto	pic pregnancy or (specify)			23d. Date of de Month	blivery Day Year
rds, P.	quires that the de an signed by the a ruid be detached t	ρ	Part II. Other significant conditions contributing	to death but not resultin	ing cause given in P	Part I.	23e. Did toba 1 🗌 Yes		o the cause of death? robably 4 Unknown	
Vital Records,		e Completed	26. Was sans referred to medical						ed? death? In No 1 ☐ Ye	utopsy lindings available completion of cause of s 2 No
	Physician: r this certifica ral director, p	ToB	25. Was case referred to medical examiner?  1  Yes  2 No  Hospital:			DOA Other: 4[		5 Desiden	ce 6 □Other (Spe	ecify)
Division of	Attending Physician: r death. sctor: After this certifici	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Year)	b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes		Describe how	injury occurred	
DIVIS		Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home building, etc. <i>(Specify)</i>	, larm, street, fa	ctory, office		Location (Stre City or Town,	et and Number or R State)	lural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Physician: 7 (Check only one) 2 Medical Examiner: On and	o the best of my knowled the basis of examination manner stated.	dge, death occi and/or investig	rred at the time, dat ation, in my opinion,	e and place, and death occurred a	due to the cau t the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
		2	29b. Signature and title of certifier	m_		D 5/2	,		1. Date signed (Mon	1
	/0		30. Name and address of person who completed		Oaku	good Ru	erd, 103	Cila	n Burn	er 15 2006 ie, MD2106
Divis	Sta Regist	ar	SEP 2 0 2006	oz. ridustrar s Signature	e for					
υHI	MH 17 Rev 1/2	UU 1			ORIGINAL					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	*	•	of Health and N e of Death		2006	29820	
	Physici		Decedent's Name (First, Middle, Las ELSII		INE HEN	NEBERGE	I.R	2. Date of Death SEPTEMBEI	<sup>™</sup> ໃ5,2006	3. Time of Death 3:06 A. M	
	/Medio Examin		4a. Facility Name (If not institution, give 3105 HUNTING TWE	street and number) EED DRIVE			Town, or Location of Death		4c. County of Death BALTI		
	Funeral Director		210 40 1027	ex □M XX F 7. Age	61 Yrs. last birtho	Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day) 04-22-1	945 9. Birth	place (State or Foreign intry) RYLAND	
	Maryland s-f show	tor	Usual Residence of Decedent           10a. State         10b. County           MD.         BALTIN	MORE	10c. City, Town o		VINGS MILLS	5		10d. Inside City Limits 1 ☐ Yes XX No	
	with the	i Direc	10e. Street and Number 3105 HUNTING	TWEED DI	RIVE	10f. Zip	Code 21117	100	g. Citizen of What Co		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Madical Exammatinat be motified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married X → Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X X If Yes, Give Year or Dates:	ever in U.S.		ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto (X) No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W		
21215-0036	within 72 hou iene. 'than "natura I'm Medical E	ompleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	college (1-4or 5)  Description	((	ecedent's Usual Give kind of work fe. DO NOT use PROFE	k done during most of work e retired)	ring	60UCHER C	ndustry OLLEGE	
and	ould be filed Mental Hyginarked other atic event, I	To Be C	17. Father's Name (First, Middle, Last)  JOSEPH	H EDMUND	HENNEBER	RGER	18. Mother's Nam SARAH	e (First, Middle, Ma KATHER]			
Maryland	id 2 should th and Men 27 is marke traumatic	_	19a. Informant's Name/Relationship (7 GEORGE DELAHUNTY	Type, Print) (HUSBAND			(Street and Number or Rui				
Baltimore,	permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once.		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of D cemetery, DRUID F	isposition (Nam crematory or oti RIDGE CE	e of her place) METERY 09-20		Cc. Location - City or T		
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licen	(R. G.I	RUTH)		Address of Facility WSON FUNERAL	. HOME, INC	1050 YOU TOWSON,		
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)										Approximate Interval Between Onset and Death	
30,	ifficate be executed g physician and as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)						
68760,	tificate b ig physic as the bi	ledicai	•	d							
P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use ar	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes XX No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 Ectopic pre			23d. Date of deli Month	very Day Year	
	equires that en signed b ould be deta	þ	Part II. Dther significant conditions of	ontributing to death bu	it not resulting in th	ne underlying ca	use given in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
1 Lecondo sale has been signed and supplemental supplemen										opsy findings available ompletion of cause of	
f Vit	Physician: r this certificantal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes ②XXNo		nt 2 ER/Outpa	atient 3 DO	0	h (Check only one) ome 5XXResiden	ce 6 ☐Other (Spec	ify)	
Division of Vital	ending P sath. or: After t he funera	The state of the s									
Divi	Hospital or Attending 24 hours after death. Funeral Director: After itely filled in by the fune	Certific	4 Homicide determined	building, etc				City or Town,			
	ths Hoep hin 24 hou the Funer npletely fill	edical	29a. Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of and manner sta	examination and/	death occurred a or investigation,	at the time, date and place, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	ree ho	- Attend	29c.	License number		d. Date signed (Month SEPTEMBER	Day, Year) 18, 2006	
	24		30. Name and address of person who a	completed cause of de	eath (Item 23a) (T)	Voth R	hoad vy 3	3 lt, no	e o M		
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 2	The last of the la	r's Signature	Sporte	0	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1407 September 19 an ancac 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4a. Facility Name (If not institution, give street and number) Hospita altimore If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 JM 2 □ F 62 Yrs. 230-54-0413 Director Jan.27,1944 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthen "natural", or Iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1X Yes 2 No Director MD N/ABaltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2528 Chase St. 21213 Ε. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7th Wood Cutter Saw Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Be 8 Cornelia Hancock other traumatic Emmitt Pannell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 5768 Red House Rd. Appromatox, VA 24522 Roxanne Haskins/Daughter laltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ŏ Depertment of mportant: If any Injury or once. GreenMount CrematorySept.20,2006 Balto.,MD 21. Signatura of Funeral Service <sup>22</sup> Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD 21213 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death Bran Immediate Cause (Final **Physician** trancoc Va disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I certificete has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 4 QUnknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 2 2 1 € 1 ☐ Yes Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Inpatient 2 ER/Outpatient 3 DOA 3/THO Other 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes After this 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 | Homicide ŏ To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee 600 N. 1 enniter 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 2 0 2006

Registrar

			1 - For State of Maryland / Dep	artment of Health and Nartificate of Death		giene Reg. No. 200	6 29822					
t	Physicia	an	1. Decedent's Name (First, Middle, Last) Richard Hugh Hoffman		2. Date of Dea Month	Day Yea						
	/Medic Examin	al-	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	Septemb	er 18 200 4c. County of De Montgome	ath					
	Funeral Director		5. Social Security Number $216-34-1896$ 6. Sex $1 \times 10^{-7} \times 10^$	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day May 13	(Year)	irthplace (State or Foreign Country)					
	e Maryland 3a-f show	ctor	Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 ☐ Yes 2 No					
	3e or 21	i Dire	10e. Street and Number 345 Chiseled Stone Road	10f. Zip Code 21784	1	10g. Citizen of What ( USA	Country?					
21213-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show samply injury or other traumatic avent, The Medical Examinar mail be motified at appea.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Mo If Yes, Give A Year or Dates:	pecify Yes or No- Rican, etc.)	14 Race - Ar Black, WI Specify: W							
	within 72 hou ione. then "nature in wedical ione."	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)									
yland 4	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Harry Hoffman		18. Mother's Name (First, Middle, Maiden Sumame) Agnes Melocik							
Mar	od 2 sho lith and I 27 is mu			ling Address (Street and Number or Ru Chiseled Stone Rd								
baltimore,	Pages 1 ar		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial 9-23-06  Marriottsv									
Dall	permit. Departm Importa any inju			22. Name and Address of Facility Haz P.O. Box 195 Sykes			& Chapel					
, i.	Physician /Medical Examiner	Examiner	d									
SOX DO/DO	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	icai										
	it the death by the atte tached for	Physician/Med		Other (specify)		Month	Day Year					
ecoras, r	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		37	to the cause of death?  Probably 4 Unknown					
Ľ	The lar ate hes page 2	Completed			1 Yes	sy prior t rmed? death 2∭No 1 ☐ Y						
Vital	Physiclan: r this certific ral director,	o Be	25. Was case referred to medical examiner? \( \) 1 \( \) Yes 2 \( \) No \( \) Hospital: \( \) Inpatient 2 \( \) EP/Outpatie	Othor	th (Check only or ome 5 Resid		Decify)					
Division of		ertification: T	27. Manner of Death  1 🛣 Natural 5 Pending (Month, Day Year) Injury  2 Accident investigation	of 28c. Injury at		low injury occurred						
Š	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: Atter completely filled in by the funer	O	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Tow	·						
	he Hosp n 24 hou he Funa pletely fil	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the or rred at the time, or	cause(s) and manner date and place, and d	as stated. ue to the cause(s)					
	To t To t	Σ	29b. Signature and fille of certifier  WTAYA  WAS	DR63579		29d. Date signed (Mo 09-18-06	nth, Day, Year)					
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Maria Tayag MD Holy Cross Hospital,	•	Rd., Sil	lver Sprin	g, MD					
2	Sta Registr	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  gistrar SFP 2 0 2006 Heres & Aparle										

				amend	State of N	per f larylar				lental Hy	giene 2	06	29823	
			4	Registrar		Death	heg. No.							
	н	Physici		Decedent's Name (First, Middle, La						2. Date of Death  Month  Day  Year			3. Time of Death	
		/Medio Examir		Norma Kittine Ha 4a. Facility Name (If not institution, given	artung ve street and number	r)		4b. City, Town, o	or Location of Death	Septem	ber 13,		6:55 a <sup>M</sup>	
				1587 Bentley C				Bel A			rd			
		Funeral Director			Sex 7. A 1 □ M 2 □ XF	ige (In yrs. 78	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	th ay, Year)	(Year) 9. Birthplace (State or Foreign Country) New Jersey			
		D		Usual Residence of Decedent										
		show	7	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				10	0d. Inside City Limits 1 ☐ Yes 2√2 No	
9	0	the M	rect	Maryland Harford  10e. Street and Number		Be	l Air	10f. Zip Code			10g. Citizen of	What Coun		
2		within 72 hours after death with the Maryland ene. then "naturet", or Items 23a or 28e-f show the Medical Exartinet Lines Le codified at	Funeral Director	336 Harlan Squa	re			21014	4		USA	TYTIAL OCUIT	,.	
7		r deat	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.		lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. Rad	ce - America		
5	36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2€ If Yes, Give Year or Dates			1 ☐ Yes 2 🔀 No		Specif	y:			
70	5-003	2 hou	15. Decedent's Education 16a. Decedent's Usual Occupation									Wh usiness/Ind	nite Justry	
1	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  12  15. Decedent's Education (Give kind of work done during most of wo life. DO NOT use retired)  12  Homemaker									ing				
	TO BE SEE TO THOMEMAKEY  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, M. M										Own Ho			
	auc	e de de de de de de de de de de de de de												
0-	ary	shou and M s mar	Paul Aloyious Kittine  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number)										Code)	
6	_	ss 1 and 2 of Health a item 27 Is		Katherine A. McG	raw / Daug			Hardwick	Road, To					
2	altimore,			1 ☑ Burial 2 ☐ Cremation 3 [	00a. Method of Disposition 1									
ó,	Ħπ			<ul> <li>4 Donation 5 □ Other (Special Service Lice</li> <li>21. Signature of uneral Service Lice</li> </ul>		St.		tius Cath 2. Name and Addre		-16-06	Forest	Hill,	_Maryland_	
1	Ba	permit. Departr Importe eny inji		Attests a	Musele		Mo	Comas Fu	neral Hom bury Road	e, P.A.	rdon Ma	razl an	J 21000	
				23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	ed the deat	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	_	Approximate Interval Between	
	-	Physician		Immediate Cause (Final disease or condition	Athen	scle	rotic	Cardo	vasculai	- Dise	ase		Onset and Death	
		/Medical Examiner		resulting in death)	Due to (or a	s a conseq	uence of):	-1101		7				
		_	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a conseq	uence of):	ellitus	740	2 4				
ν		be executed sician and burial-transit	Examiner	that initiated events	· Hup	erte	24570	4						
	760,	be executed ician and burial-transit		resulting in death) Last	+ /	s a conseq	1 1		9					
	687	9 % 0	edical	•	d. 1796.		ZIEJ J	evolem	14					
	×o	h certifi anding use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7e			23d. Da	te of deliver	гу	
	P.O. Box	e death	sicla	in the past 12 months? 1 Yes 2 No	1 □Live birth 4 □Pregnant a 9 □ Unknown			Ectopic pregnancy Other (specify)	/		Mo	onth E	Day Year	
	P.0	that the		9 ☐ Unknown  Part II. Other significant conditions		but not res	ulting in the m	nderlying cause gry	en in Part I	23e Did t	obacco use cont	tribute to the	e cause of death?	
	of Vital Records,	uires l signe	d by					ndonying odddo giv	on are are a	1 🗆	V-/		ably 4 Dunknown	
	000	aw req	Completed							24a. Was	an 24b.	Were autop	osy findings available appletion of cause of	
	Ä	The late ha	Com							autor perfo	rmed?	prior to com death? 1 □ Yes 2		
	Vita	icien: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			046	26. Place of Death				Daughter's	
	of	Phys rrthis aral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj	iury	ER/Outpatien 28b. Time of		4   Nursing Ho	-/-	tence 6XIOth	er <i>(Speci<mark>n</mark></i>	esidence	
	ion	ath. rr: Afte	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injury		k? Yes 2 □ No					
	Division	or Atter fter de pirecto n by th	ertification;	3 Suicide 6 Could not be determined	200. Flace of II	njury - At ho	ome, farm, str	eet, factory, office		28f. Location (	Street and Numb	er or Rural	Route Number,	
		pltel o	O	29a. Certifier Certifying Pl	nysician: To the bes	t of mu kno	winden dont	a conversed at the tir	no data and place	and due to the				
		To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Example one)	miner: On the basis and manner s	of examina	tion and/or in	vestigation, in my o	pinion, death occurr	ed at the time,	date and place,	and due to	the cause(s)	
		To the comp	M	29b. Signature and the of certifier	1	MI	n	29c. Licens		_	29d. Date signe	/		
		_		To	nous	1-11	/	1000	3925	8	7/1	3/2	2006	
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			For State Registrar		State	of Maryla	and / Depa <i>Ce</i>	artment of I	lealth ar Death	nd M	ental Hy	gien Reg. N		16	29	824	
	Physici		1. Decedent's Name (i	First, Middle,		lie Cha	arles Jo	ohnson			2. Date of Do Month Septer	eath Da	19,20	ar 0.6	3. Time of 2:15	Death A M	
	/Medic Examir		4a. Facility Name (If no	ot institution, g				4b. City, Town,	or Location of	Death	J-F		c. County of D				
1	Z.Adiiiii		Montgomer	cy Gene	ral Hos	pital		Olney	Olney				Montgo	mery	,		
	Funeral		5. Social Security Num	ber 6	. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24	4 Hrs.	8. Date of Bi (Month, D	rth	9.		ce (State o	r Foreign	
	Director		509-32-41		1 <b>∑</b> M 2□F	68	Yrs.	Months Days	110013		June 8	3, 1	938 K	ansa			
	and **		Usual Residence of De	ecedent 0b. County		10c.	City, Town or Lo	ocation						100	I. Inside Cit	tv I imits	
	daryti f eho	5			George									100	1 🗆 Yes	•	
	286-	Director	10e. Street and Number		George	ПС	aurel	10f. Zip Code				10a C	itizen of What	Countr	u?		
	with Sa or	0	16026 Jer		ad			20707					S.A.	COUNT	, .		
	me 2	Funeral	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of I	Hispanic Origi	in? (Spec	cify Yes or N		14. Race - A	mericar	Indian,		
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28e-f ehow the Medical Exercipe mast Le ricifilied at	þ	1 Never Married		Armed F 1 XYes If Yes, G Year or [	2 □ No ive	-	If Yes, specify Cub 1 ☐ Yes 2🖔 No		Puerto F	Rican, etc.)		Specify: W				
2-0	72 ho	ted		5. Decedent's			16a. Dece	dent's Usual Occu	pation	of working		16b. I	Kind of Busine				
21	thin 7	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Field Engineer  Ae															
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	1 and Healt em 2		Lois H. W	<u>'</u>	spouse	206	. Place of Dispo	26 Jerald			ireı, N		Land 21			- h	
Ď	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		1 □ Burial 2 🖾 🤇	Cremation 3		State	cemetery, cres	natory or other pla								1	
Baltimore,			4 ☐ Donation 5		-	144 -		el Cremat					enton,	Mar	утапо	į	
Ba	Depe Impo eny is	M00773 Donaldson Funeral Home, 313 Talbott Ave. Laurel									urel,	Mar	yland :				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition AMELODYS PLASTIC 3 YNDONE														
	Physician / /Medical		disease or condition resulting in death)	wii	-			457ic	224	ひろり	mE						
	Examiner		,	- 1	Due to	(or as a cons	equence of):										
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-	the a	Physician/Me	1 ☐ Yes 2 ☐ N 9 ☐ Unknown		4∐Preg 9∐Unkr	nant at time o nown	fdeath 5□	Other (specify) _					WORTH	D.	ау і	oa:	
P.0	that the de sed by the a detached i		Part II. Other significa	int condition:	contributing to	death but not r	esulting in the u	nderlying cause gi	ven in Part I.	-	23e. Did	tobacco	use contribut	e to the	cause of de	eath?	
Records,	The law requires that the death certifules has been signed by the attending age 2 should be detached for use a	ted by										Yes 2			ly 4 □U		
ecc	e law r hes be	Completed									24a. Was		24b. Were	autops	y findings a	available ause of	
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Vital	ysicien:   is certifical director, p	Be	25. Was case referred examiner?	to medical	Line State					of Death	Check only	one)					
of	G S X	은	1 ☐ Yes 2 No 27. Manner of Death				☐ ER/Outpatier	I JU DON					6 ☐Other (S	Specify)			
		io	1 Matural	5 Pending		of Injury oth, Day Year)	28b. Time of Injury	Wo	ryat rk? ]Yes 2.∐No		8d. Describe	now inju	iry occurred				
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οį	after after Direction by	Certification:	4  Homicide	determine		ling, etc. (Spe		cot, tactory, onlos			City or To	wn, Stat	(e)	Tidrati	iodio manni	,or,	
	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune.	Medical C	(Check only 2	Certifying Medical Ex	aminer: On the t	pasis of exami	nowledge, death	n occurred at the ti	me, date and opinion, death	place, ar	nd due to the	cause(s	s) and manner	as state	ed.	,	
	To the Ho within 24 I To the Fu completely	Mec	one) 29b. Signature and tit		and mar	nner stated.		29c. Licen:			T		ate signed (Me				
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,	621		30. Name and address	of person wh	Omnleted care	se of death (III	em 23a) /Tura	_	2 00 2	> 2		J 15 P	TEMB	-10	17,2	000	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2000 enevieve /Medical 4c. County of Death la. Facility Name (If not institution, give street and number) or Location of Death Examiner ge (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security 8. Date of Birth (Month, Day, Year) Funeral 1□M 21 F Months Min Days Hours Director 71 218-40-7965 MAR 10 1935 MARYLAND Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28e-f ehov Examiner must be notified at 1 XYes 2 No MARYLAND N/A BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 23a 741 N FULTON AVE 1st Flr. deeth Completed by Funeral 21217 U.S.A Items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X Xo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 20 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2XXNo Specify: Specify: BLACK 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I'm Me Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than other treumatic event, the M PRIVATE 11th grade DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ GEORGE LEE CLARA BAILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Dorsey/Granddaughter BALTIMORE, MD 21217 20c. Location - City or Town, State 923 N STRICKER ST., 2nd flr, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
eny injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 09-22-06 LANSDOWNE, MARYLAND April Santo Lipego 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 21. Signature of Fu Mosun 23a. Part. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy - 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy certificate Asrial 2000 2000 1 ☐ Yes Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 No death. 2 Accident within 24 hours efter death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical ‡ 29b. Signature and title of certifier 29c. License number eath (Item 23a) (Type, Print) K.A. Kori 32. Registra 31. Date filed (Month, Day, State carte Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 29826 For State Amend item#1, perMD, G859, 9/20/06 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) Violet A. Branford Johnson 2. Date of Death 3. Time of Death Day Month **Physician** 2 254 M SEPTEMBER 08, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BON SE cours BALTIMONE ITAL If Under 1 Year | II Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct 13, 1935 9. Birthplace (State or Foreign **Funeral** Min. Maryland Days 1 ☐ M 2 🛛 F Months Hours 219-30-7134 70 Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-4 showery injury or other traumatic event, ILA Medical Exactions must be notified. 1 Yes 2 No Baltimore Maryland N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1105 Scott Street 21230 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Klo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Bowie Herman Bowie ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1158 Nanticoke Street Baltimore, Maryland 21230 Ida Myers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 09/14/06 Crownsville, Md. Crownsville Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licey 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused he death, shock, or heart lailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONI A Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, REWAL OISEASE 2 No 1 ☐ Yes 3 Probably 4 Unknown Be Completed been 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No this certificete has 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) with 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SECOUNS HOSPITAL MILLEN BON THOMAS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMBER 18,2006 12:49 m **Physician** MOLLY BRUCE JACOBS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE BRIGHTWOOD TIMONIUM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1□M 2□X 77 055-26-1165 Yrs Director OCT. 13,1928 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at MD 1 ☐ Yes 2 No BALTIMORE STEVENSON **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 933 HILLSIDE RD. 21153 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or iteme 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: þ 3 ₩idowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry COMMUNITY at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) VOLUNTEER SERVICE permit. Pages 1 and 2 should be file Department of Health and Mentat Hy Important: if Item 27 is marked other any lighty or other treumatic event, SDR8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HELEN WHITRIDGE ALBERT CABELL BRUCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 179 CLIFTON ST. BELMONT, MA 02478 SALLY JACOBS daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition GREEN MOUNT 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SEPT. 20, 2006 BALTIMORE, MD 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 21. Signature of Furieral Service Licenses 16924 YORK RD. MONKTON, MD 21111 ONARD 23a. Part1. Enter the the ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart to ture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) trtenoscieratic cardiovascular **Physician** DUS. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at the detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? cate as pag. 1 TYes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death

1 Alatural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the within 24 hours after deatl To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifie certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 025643 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 FaulonemD/6565 N. Charles St/Sulte 209, 32 Registrar's Signature-31. Date filed (Month, Day, Year) State SEP 2 0 2006 Registrar

		-	For State Registrar	State of Maryland / D	Department of He Certificate of D	ealth and Mer Death	ntal Hygien		29828
	Physici /Medic Examin	al .	1. Decedent's Name (First, Middle, Last  Sherman  4a. Facility Name (If not institution, give	Johnson	4b. City, Town, or l		Date of Death Month Di	. )	3. Time of Death
	Funeral Director		5. Social Security Number 6. Se	40	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month Day, Year 22 12 19	9. Birthpla Country	ce (State or Foreign
	ne Maryland 8e-f ehow pillied at	ctor	10a. State 10b. County N/A	10c. City, Town	itimore				d. Inside City Limits
	pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23e or 28e-f ehow any njurty or other traumatic event, the Medical Examinal must be notified at ance.	Funeral Director	10e. Street and Number 907 Argyle 11. Marital Status	AVENUE  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His	spanic Origin? (Specify, Mexican, Puerto Ric	y Yes or No-	itizen of What Countr	n Indian,
21215-0036	72 hours after natural', or it ical Examin	<u>م</u>	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grace)	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 Yes 25 No  Decedent's Usual Occupat (Give kind of work done du	Specify:		Specify: Bla	ck
d 2121	filed within 7 Hygiene. other then "r ent, the Med	e Completed	Elementary/Secondary (0-12) 12-th yew  17. Father's Name (First, Middle, Last)	Coltege (1-4or 5+)	Salcsn		irst, Middle, Maide	Retail	
Maryland	should be and Mental s marked o	To Be	Witey Tyson  19a. Informa Nam elationship (T)		. Mailing Address (Street ar	_	oute Number, City	or Town, State, Zip C	_
	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trai		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ I	Removal from State cemeter	Disposition (Name of ry, crematory or other place		20c. l	_ocation - City or Tow	n, State
Baltimore,	permit. Pa Departmen Important any injury once.		4 □ Donation 5 □ Other (Specify,	17 (7 (7)	Cemetery 22 Name and Add a 22 Name (Add) 24 Name (Add)	s of Facility Greene Fur Load Ba	eral Sev Etmore	altimore. Vices Vib21212	, 11410
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death. Do not cause on each line.	not enter the mode of dying	, such as cardiac or re	espiratory arrest,	í	Approximate nterval Between Onset and Death
	/Medical Examiner	<u>-</u>	Sequentially list conditions, if any, leading to anniediate cause. Enter Underlying	b. Renal fur.	lune		•	i	week
30,	death certificate be executed e attending physician and affor use as the burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. EA Sac	AIOS			1	week
x 68760,	as as	/Medica	IF FEMALE:	d. — Km.) homa 23c. If yes, outcome of pregnancy				23d. Date of delivery	week
P.O. Box	thet the death cer ed by the attendir detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 □ Fetal death 4□ Pregnant at time of death 9□ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				<b>yay</b> Year
	law requires thet the as been signed by th 2 should be detache	6	Part II. Other significant conditions co	ntributing to death but not resulting in	n the underlying cause giver	n in Part I.	23e. Did tobacco	use contribute to the	cause of death?
al Reco	vician: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				24a. Was an autopsy performed? 1 Yes 2 N	prior to comp death?	sy findings available pletion of cause of
of Vit	Physicia this certi al directo	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 ER/Ou	tpatient 3 DOA Other	4   Nursing Home	5 Residence	6 ☐Other (Specify)	
Division of Vital Records,	Attending I r death. ector: After by the funer	Certification:	27. Manner of Death t Matural 5 Pending investigation 3 Suicide 6 Could not be determined			es 2 □No	I. Describe how inj  Location (Street a City or Town, Sta	and Number or Rural	Route Number,
۵	To the Hospital or within 24 hours after To the Funeral Dir completely filled in its	Medical Cer	29a. Certifier 1 V Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my knowledge iner: On the basis of examination an and manner stated.	a, death occurred at the time d/or investigation, in my opi	e, date and place, and inion, death occurred	I due to the cause( at the time, date a	s) and manner as sta nd place, and due to t	ted. he cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier	7m0	29c. License	number 5435 F1665		ate signed (Month, D	
	2		30. Name and address T person who d		(Type, Print)			1	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Acarts'	1			

7. Age (In yrs. last birthday)

Certificate of Death

Towson

4b. City, Town, or Location of Death

1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry U.S. Coast Guard 18. Molher's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 20c. Location - City or Town, State Arlington National Cem 9-29-2006 Arlington, Virginia Inc. Columbia, MD 21045 Approximate Interval Between Onset and Death menters 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 405 Pie 28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State) 29c. License number 29d. Date signed (Month, Day, Year) D58303 September 14 2005 address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles

600 N. Charles It Barune Charles 21204

2. Date of Death

September

Month

Day

14,2006

Baltimore

4c. County of Death

29829

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

North Carolina

4:15 A M

To the Hospital or Attending Physicien: within 24 hours e To the Funeral I ပ္

> State Registrar

30. Name and address of person with the complex of

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

John William Kime

Gilchrist Hospice

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

**Funeral** 

06-06919 Cynthia Kovak

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2	$\cap$	0	6	2	0	0	2	
	U	U	$\Box$		7	$\alpha$	J	U

	1- For State Registrar	Certificat	e of Death	Re	g No 200	6 2983
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	Kovak		2 Date of Death Month Septembe	Day Year	3. Time of Death 1458 hrs
	4a Facility Name (if not institution, give stre Peninsula Regional Medical C	*	4b City, Town, or Location of Salisbury	f Death	4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 6. Sex 135~60~9973 1 M	7. Age (In yrs. last birthda	ay) If Under 1 Year If Under Months Days Hours	24Hrs 8 Date of Birt Min. 08/22/	h(MM/DD/YYYY) 9. Birth 1959 Foreign Cou	
nd show any ce.	Usual Residence of Decedent  10a State  10b. County	10c. City, Town or Eden	Location			10d Inside City Limits 1 Yes 2 X No
with the Maryland ns 23a or 28a-f show be notified at once. aral Director	10e. Street and Number 5047 Camparound Ro	oad	10f. Zip Code <b>21822</b>	10	Og Citizen of What Coun	try?
r death or iter must Fune	11. Marital Status 1 Never Married 2 Married 1 S Widowed 4 Divorced by D	Armed Forces?  Yes 2 No s, Give Year ates:	3. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 No specify:	Puerto Rican, etc )	White, etc.	an Indian, Black,
~ 1 = 1 7	15. Decedent's Education (Specify only his Elementary/Secondary (0-12)		cedent's Usual Occupation (Give king most of working life. DO NOT a	use retired)	16b Kind of Business/Ir Beaut	,
21215-003 uld be filed withi Mental Hygiene marked other th c event, the Med	Michael	Hickel	E:	s Name (First, Middle, M lsie	Not k	
MD 2121; d 2 should be fil tht and Mental Is n 27 is marked tumatic event,	19a. Informant's Name/Relationship (Type, Bruce Kovak, Jr	son 2	Mailing Address (Street and Num 72 Twin Oaks Te	rr., Westfi	eld, NJ 07	090
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Nornal Hygene Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple	20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other Specify  21 Signature of Funeral Service Licensee	emoval from State crematory Hillto	Disposition (Name of cemetery, or other place)  p Serv Corp  22. Name and Address of Facility	9/18/06	Towson, MD	
Physician	23a Part I. Enter the disease, or complication		1050 York Rd.,	Towson, MD	21204	Approximate Interval
/Medical xaminer	failure. List only one cause on each lir Immediate Cause (Final disease a					Between Onset and Death
ted of insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consequence of): o (or as a consequence of):				
760, icate be executed thy sician and the burial - transit	X UNPENDED an	ENDED item#23a,PII,	27,perME,g860,10/12	/06 TT		
tox 6876 eath certificat attending pheror is attending pheror in the for use as the control of t	23h Was decedent pregnant in the	c If yes, outcome of pregnancy	Fetal death 3 Ectopic Other (Specify)		23d Date of delivery Month D	ay Year
i, P.O. Brites that the dispense by the detached by the detached by Physical by Physical by Physical brites and by Physical brites are sent that the detached by Physical brites are sent to the detached by Physical brites are sent to the detached by Physical brites are sent to the detached by Physical brites are sent to the detached by the detached	Chronic alcoholism		n the underlying cause given in Pai		bacco use contribute to t	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staffer death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P				24a. Was a autop: perfor	sy prior to co med? death?	opsy findings available ompletion of cause of
Fital Receivital Receivant The is certificate lifrector, page	25 Was case referred to medical examiner?  1 ✓ Yes 2 No	al: 1 Inpatient 2 ✔ ER/Outp	26.Place of Death (		Residence 6 Other	
ion of Vi tending Physicath or: After this the funeral di	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year) 28b. Tin	ne of Injury 28c Injury at Work*		low injury occurred	
Division o  Hospital or Attending 44 hours after death Funeral Director: Aft tely filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At home, farm (Specify)	I, street, factory, office building, etc	28f. Location (S or Town, Si	treet and Number or Rur tate)	al Route Number, City
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On and	To the best of my knowledge, death the basis of examination and/or invi- manner stated	estigation, in my opinion, death occ		and place, and due to the	cause(s)
> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	29b. Signature and title of certifier		29c License number O.C.M.E.		29d. Date signed (Mon September 14, 20	
Sac		edical Examiner 111 Pe	nn Street, Baltimore, MD	21201		
State Registra		32. Registrar's Signature	freels.			

State of Maryland / Department of Health and Mental Hygiene 2006 29831 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2:25 P Wanda (nmn) Kowalski Sept. 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21223 Gunpowder Road Manchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2√2 F Yrs. Director 27, 1925 New Jersey 212-76-1555 80 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event. The Medical Exeminar must be notified at 1 Yes 2 No Director Maryland | Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itame 23a 21223 Gunpowder Road USA 21102 Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced natural White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) O Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen (nmn) Kowalski Veronica (nmn) Matejek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence O. Harris/Brother-in-law 1502 Van Bibber Rd., Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of h
Important: If ite
eny injury or of 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cokesbury U. M. Cem 9-19-06 Abingdon, Maryland 21. Signature of Furnalal Service Censee Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, Maryland 21009

ADDROXIMATE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one decise on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) nelas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe rder 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ce ficate 2 110 1 ☐ Yes 2\_ 1 Yes : After this cellification, in Hospital or Attending Physician: 25. Was case referred to medical examiner? 음 26. Place of Death | Check only one Other: 4 Nursing Home 5 Handence 6 Other (Specify) ပ 1 ☐ Yes 2 🛂 🗸 🗸 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 A atural 5 Pending Injury М 1 Tes 2 No hours after death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Turnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie cal completely Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21120 Richard Habersat, MD 111 Mount Carmel Rd., Parkton, MD 31. Date filed (Month. Registrar's Signature State 2 2008 Registrar

### 06-06977 Judith Blair Lochary

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1-For State Registrar Certificate of Death Reg No. 2006. 2983
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Judith Marie Blair Lochary</b> JUDITH M. LOCHARY  2. Date of Death Month Day Year September 15, 2006  1218 hrs
	4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Atlantic General Hospital 4c. County of Death Worcester
Funeral Director	5. Social Security Number 215-42-0550 1 M 2XXF 63 Yrs 63 Yrs 63 Yrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country/MARYLAND)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   10b. County   10d. Inside City Limits   1   Yes 2 XX No
Physician /Medical 5xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of).
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    X UNPENDED
n of Vital Rec ling Physician: The I After this certificate funeral director, page on: To Be Com	25. Was case referred to medical examiner?  1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 2 No 26 Place of Death (Check only one)  1 Ves 2 No 1 Ves 2 No 26 Place of Death (Check only one)  1 Ves 2 No 26 Place of Death (Check only one)  1 Ves 2 No 26 Place of Death (Check only one)  1 Ves 2 No 26 Place of Death (Check only one)  1 Ves 2 No 26 Place of Death (Check only one)  26 Place of Death (Check only one)  27 Manner of Death 28a Date of Injury (Month, Day, Year)  28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred
Division o  To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune Medical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a Certifier 1 Certifying Physician: To the basis of examination and/or investigation, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
Me G P S F S P	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  September 16, 2006  30. Name and address of person who completed cause of death (Item 23a)
State Registrar	The state of the s

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 (Certificate of Death

			For Stata Registrar	State of Maryla	nd / Depai <i>Cert</i>	tment of H ificate of I	leaith and N Death		giene 20 (	06 29833
	Physicia /Medic		Decedent's Name (First, Middle, Last)	Clyde	Lomax			2. Date of De. Month	Day Y	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give : BALTIHORE WASHING	TON MEDICAL	CENTER	GIEN	BURNIE			ARUNDEL
	Funeral Director		213-18-6489	M OFF	. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da May 2	th y, Year) 23, 1921	Birthplace (State or Foreign Country)     New Jersey
Manyland	fed at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland	10c. C	ity, Town or Loca		Baltimore			10d. Inside City Limits 1 □¥es 2 □ No
with the	3a or 28a	Il Director	10e. Street and Number 2725 Bookert Drive			10f. Zip Code	21225		10g. Citizen of Wh	nal Country? U.S.A.
SFL 1215-0036 within 72 hours after death with the Marviand	f Health and Mental Hygiene. Item 27 is marked other then "natural; or items 23e or 28s-f ehow other traumatic event, I'm Medical Examinating the colling at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in the Armed Forces?  1 ** Yes* 2 ** No If Yes* Give	4040	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Race - Black,	American Indian, While, etc.
$\mathcal{LOHAX}$ $\mathcal{OKB}$ $\mathcal{LEL}$ Baltimore, Maryland 21215-0036	'natural', dical Exe	leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu (Specify only highest grad	Year or Dates:	1946	nt's Usual Occur		king	16b. Kind of Busi	Black iness/Industry
$/\mathcal{SE}$	Hygiene. ther then nt, the My	Completed	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	iire. Do		ehousemen		Monarc	ch Food Company
C/g aryland	and Mental Hygiene. Is marked other than sumatic avent, I to M.	To Be		nown	19h Mailing	Address (Street			Mary Bank	
4 X X e, Ma	of Health an If Item 27 is or other trau		Dorrese Lomax Wife 20a. Method of Disposition		27 Place of Disposi	'25 Bookert	Drive Baltimo			
Altimore, M.	ant: If ury or		1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify)  21. Signature of Funeral Service/Licens		Maryland N	atory or other place lational Park Name and Addres	c Cemetery	09/25/06		rel, Maryland
Balt Balt	Depo Impo		23a, Part I, Enter the disease, or combi	cations that caused the dea	10	Estep   1300 B	Brothers Fundataw Place F	Baltimore, N	fd 21217	Approximate
E	hysician /Medical xaminer	iner	shock, or heart falure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. Lary Leafing Lamber Islands (Disease or injury that initiated events	Due to (or as a conse	quence of):	INFAY	RCTION	J		Interval Between Onset and Death
68 60, <sup>4</sup>	physicia s the bur	edicai Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
Division of Vital Records, P.O. Box (	ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗆 E	Ectopic pregnancy Other <i>(specify)</i>	,		23d. Date of Month	
ords, F	been signed should be dei	þ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the und	lerlying cause giv	en in Part I.			oute to the cause of death? Probably 4 □Unknown
I Reco	ete has be	Completed							rmed? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vita	is certificete hi director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	feno	- Oth	26. Place of Dear			
on of	th. : After this : funeral di	tion: To	27. Mann of Death  1 Valural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 €  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	y al k? Yes 2 □ No		dence 6 Other now injury occurred	
<b>5</b> 5	를 들는 를	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stree	et, factory, office		28f. Location (: City or Tox	Street and Number wn, State)	or Rural Route Number,
The Hospital	n 24 hours ne Funsra sletaly fille	Medical (	29a. Certifier 12 Cartifying Phy (Check only one) 2 Medical Exami	ner: On the bast of my kr ner: On the basis of examin and manner stated.	n Wedge, death nation and/or inve	ecumed at the broastigation, in my o	ne data and place pinion, death occur	and due to the rred at the time,	dausa(s) and many date and place, and	er as stated. d due to the cause(s)
	To the comp	Ň	29b. Signature and title of certifier	feai 1	MD	29c. Licens	1 10 Lf	2	29d. Date signed (	Month, Day, Year) BER 19, 2006
	18		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type, P	rint) USH	BALT	MULA	E MI	) 21226
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	12 1		,	(	•

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 29834 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 19, Sep. 2006 1:00 A Ada R. Leight /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Cherrywood Reisterstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M XXF 78 Yrs. Director Nov. 6,1927 Maryland 218-22-2163 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MO40 27 is marked other than "natural", or Iteme 23a or 28a-f ehov traumatic event. Its Madical Examinational Committed at MD Baltimore 1 ☐ Yes XXNo Director Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3317 Carroll Ave. 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ind Mental James Fram Ada Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 i Merle M. Leight, Jr. /Husband 3317 Carroll Ave, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Himportant: If Ite any injury or ot once. 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory Inc. 9/20/06 4 □ Donation 5 □ Other (Specity) Baltimore, MD 21. Signature of Line al Service License 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onser and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) vasculen disease **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 Z No o 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by uust 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 4b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has the autopsy performe 1 Yes 2 🗹 of Vital After this certification funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place Death Check only one Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 1838 Greens Tree Pd und 30. Name and address of person the completed cause of death I IN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State

Registrar

Daska J

3301 New Mexico Ave., N.W. #350, Washington, D.C. 20016

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

32. Registrar's Signature

Thomas L. Sacks, M.D.

SEP 2 0 2006

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryland /	•	ment of Health and icate of Death	d Mental Hy	giene Reg. No. 200	6 29836
	Physici /Medic		1. Decedent's Name (First, Middle, Last	;)		LAWSON	2. Date of Dea Month Septem	ath Day Yea	3. Time of Death
	Examir Funeral Director	er	213-87-1001	Hospital	birthday) If	City, Town, or Location of De Baltmore Under I Year If Under 24 Fonths Days Hours N	City	4c. County of D	Birthplace (State or Foreign Country) Maryland
	Maryland -f ahow	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland	10c. City, To	own or Location	Baltimore			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23e or 28e	Funeral Director	10e. Street and Number	Rd.	1	0f. Zip Code 2/229		10g. Citizen of What	Country?
980	be tiled within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or itama 23e or 28e-f ahow avent, the Medical Examinar must be rediffed at	by	11. Marital Matried  1 Prever Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Decedent of Hispanic Origin? s, specify Cuban Mexican, Pu Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. Ac.K
21215-0036	od within 72 ho giene. er then "netu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation 16 completed) 16 College (1-4or 5+)	(Give kind	s Usual Occupation of work done during most of NOT use retired)  COOK	working	16b. Kind of Busine	ss/Industry 's Restaurant
aryland	ould be tile Mental Hy arked othe	To Be C	17. Father's Name (First, Middle, Last) Donald Lawso	ĸ			Name (First, Middle,		
Σ	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (T. Shuron Laws) 20a. Method of Disposition	n-sister		Ma Khan Ro	i 1/2/11:	11	ryland 2001
Baltimore	permit. Pages Department of I Important: If its any njury or o		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify 21. Signature of Full 1) Service Licen	Removal from State	210 C 22. Na	emetery me and Address of Facility	1/22/06 arker Fu	Landsdo. neral Hom	une Maryland
	Ø □ 듯 € O		23a. Part1. Enter the disease, or comp shock, or heart failure. List only compared to the comp	lications that caused the death. Dine cause on each line.		FredericK A e mode of dying, such as card			Approximate Interval Between Onset and Death
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypoxic res			e neumor	nia.	2 hours
8760,	rificate be executed by physicien and as the burial transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Retroviva 1  Due to (or as a consequence	nfect	10n	ricultur	na -	20 years
P.O. Box 68	death cer e attendir d for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	ath 3 ☐Ecto	opic pregnancy ner (specify)		23d. Date of o	delivery Day Year
	quires that n signed by		Part II. Other significant conditions co	ntributing to death but not resulting	g in the underl	lying cause given in Part I.	23e. Did to	M	to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	The law requires that the cate has been signed by the page 2 should be detached.	Completed						prior t rmer? death	autopsy findings available o completion of cause of ?
Vita	Physician: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: W.		Other	Death (Check only o		
ion of	To the Hospital or Attanding Physician: within 24 hours alter death. To the Funerel Director: Atter this certitic completely litled in by the funeral director.	atlon; To	1 Yes 2 Volume  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ERV	b. Time of Injury	28c. Injury at Work?  1 Yes 2 No		dence 6 Other (S	pecify)
Divis	ital or Attars atter de:	Certification;	3  Suicide 6  Could not be 4  Homicide determined	28e. Place of Injury · At home, building, etc. (Specify)	, farm, street, f	factory, office	28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dir completely tilled in	Medical	Une)	sician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death occ and/or investig				
	or with or no	2	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo	inth, Day, Year)
	7		30. Name and address of person who c	ey Medical Do ompleted cause of death (Item 23a	a) (Type, Print	Kes-00	U S	eptembe	r 15, 2006
	Sta		Kendall Moseley, The 31. Date filed (Month, Day, Yelir)	ey Medical Do ompleted cause of death (Item 23a 2 Donns Hopkins H 32. Registrar's Signature	(cspital	, 600 North No	ife Street,	Baltimore 1	Maryland 21287
	Registr	ar	SEP 2 0 2006	place is to	1000CC				

			- For Amend item#17,pe	State of Mar riffi, 6859, 972	yland / Depa Cei	artment of H	ealth and Death	d Mental Hyg	iene <sub>eg. No.</sub> 20 (	06 29837
	in the second	- 19	Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day	3. Time of Death
3	Physici /Medic		Irvin E. Metzle	r				Septemb	er 15, 2	006 8:35 A M
For .	Examin	4	4a. Facility Name (If not institution, give st			4b. City, Town, or		eath	4c. County of	
		44	Longview Nursing H 5. Social Security Number 6. Sex		In yrs. last birthday)	Manche:	ster If Under 24 F	Irs. 8 Date of Birth	Carro	3. Birthplace (State or Foreign
	Funeral Director			M 2□F	78 Yrs.	Months Days		in. 8. Date of Birth (Month, Day Oct • 20	,1927	Countay) Maryland
	ס		Usual Residence of Decedent							
	anylan show	_	10a, State 10b. County	1	Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	28a-f	Director	Maryland Carroll  10e. Street and Number		wesu	ninster			Og. Citizen of Wh	
	with With	급	1600 Samscreek Roa	a		2115	7	'	U.S.A.	lat Country :
	ms 20	Funeral		2. Was Decedent Ev	er in U.S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian,
9	or Ite		1 ☐ Never Married 2 🎇 Married	Armed Forces? 1 □ Yes 2 □ No If Yes, Give		if Yes, specify Cubai 1 □ Yes 2 <b>⊠</b> No		erto Hican, etc.)		White, etc.
5-0036	72 hours after death with the Maryland natural, or Items 23s or 28s-f show dical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	WW 11				Specify:	White
15-	"nati	lete	15. Decedent's Educa (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done a DO NOT use retired,	ation furing most of v )	working	Baltimo	re Symphony
2121	filed within Hygiene. ther then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		tenance E			Orchest	ra
b	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the Mi	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle,	Maiden Surname)	
ylaı	nould b	10	UKKnown I	ois C. Metz	ler		Anna	Muth		
Maryland	ii. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heath and Mental Hygiene. Creant: if item 27 is marked other than "natural; or items 23a or 28a-f show injury or other traumatic event, the Madical Examinat must be notified at any or other traumatic event, the Madical Examinat must be notified at a.		19a. Informant's Name/Relationship (Type Anita Metzler (W	e, Print) ife)		ng Address (Street a Samscreel		Rural Route Number Westmins		
	1 and 2 Health tem 27		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		-		ity or Town, State
10H	ages ent of nt: ff it		1   Burial 2 □ Cremation 3 □ Re  Donation 5 □ Other (Specify)	moval from State	Crownsvi Cemetery	iie veter	ans 9_	22-2006	Crownsvi	lle. MD
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licenses	A		Name and Addres itzke Fune 555 Twin l			umbia, M	
	3 30	$\Box$	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused th						Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a		1		1 .1		X-7-12
	Examiner		Esquentially list conditions, if any, leading to immediate	Cereb	rovase	ular O	cen	lent Diseas		4 when
_	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	a Africa	consequence on.	to 110		Dres.		2011111
12	execu n and al-trai	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	0	sen an	, , , , , , , , , , , , , , , , , , , ,	~	a ofte
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9	certificate be iding physicia ise as the bur	e e	IF FEMALE:							
Вох	ath tter or u	lan/l	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1☐Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date Monti	
o.	D 00 D	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at tir 9☐Unknown	me of death 5L	Other (specify)				
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rds	quires n sign	d by				<b>.</b>		1 □ Y	es 2 No 3	Probably 4 Unknown
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on	Jing Afte fune	Ê	1 Natural 5 Pending	28a. Date of Injury (Month, Day	rear) 200. Time o	Work	rat ⟨? Yes 2 □No	28d. Describe n	ow injury occurred	
Division	Attending r death. sctor: Atte	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	/ - At home, farm, st			28f. Location (S	treet and Number	or Rural Route Number,
Ö	s after	Certification:	4 Homicide	building, etc.	(Specify)			City or Tow	n, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai (	29a. Certifier (Check only one) Certifying Physical Examination)	cian: To the best of er: On the basis of e and manner state	xamination and/or in	h occurred at the tim vestigation, in my op	ne, date and planting of the control	ace, and due to the c ccurred at the time, d	ause(s) and manr late and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	0 . / .	, and	29c. License				(My th. Day, Year)
			I cham is	nine	itm M.	コークス	544	13	7/18/	2006
	541		30. Name a address of person who cor	npleted cause of dea	th (Item 23a) (Type,	Print)	11.4	minster,	mio	1157
100	State	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	ma,	-vest	ין שוצמו מני		-1.71
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			For State Registrar	State of Ma		d / Depa		t of H	ealth an		Il Hvaie	ne No. 200	
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Marguerite     4a. Facility Name (If not institution, give Saint Joseph		uelle	-	4b. City,	Town, or	Location of D	SEF <sup>M</sup> f	e of Death	₹ <sup>ay</sup> 17, <b>2</b> ¢ 4c. County of D	3. Time of Death 4:30 Am eath itimore
	Funeral Director		Social Security Number 6. Sep.	7. Age		ter ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 h	Hrs. 8. Dat Ain. (Mo	e of Birth onth, Day, Ye		altimore  Birthplace (State or Foreign Country)  ryland
	Maryland a-f ehow filed at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	2	10c. City	, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ Xlo
	ath with the 23a or 28a	Funeral Director	10e. Street and Number 44 Windemere Pkwy	10.14/22 Decodes 1	i= 11 C			131	O-1-1-1	2 (0		USA	
900	within 72 hours after death with the Maryland ane then "natural", or iteme 23a or 28a-f ehow the Medical Exarthar must be indiffed at	d by Fune	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		1	Yes, spec		spanic Origin? n, Mexican, Pi Specify:	r (Specify Ye uerto Rican, (	etc.)	Black, W	merican Indian, hite, etc. White
21215-0036	d within 72 h giene. er then "natu tre Medica	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		+)	16a. Deced (Give life. L	kind of wo DO NOT u	rk done d se retired)	tion uring most of	working		elephone	•
Maryland	hould be file id Mental Hy marked oth matic event	To Be (	17. Father's Name (First, Middle, Last) Addison  19a. Informant's Name/Relationship (Ty	Engle	ebrec		a Address		Bert	ha		den Surname)  Mind ity or Town, State	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exact instituted for notified at ance.		Harry A. Mueller  20a. Method of Disposition  1 🛱 Burial 2 □ Cremation 3 □ R	- Husba	20b. Pla	44 Wi ace of Dispo	ndeme	ere P	kwy, P	hoeni x	, Md.	21131 Location - City	or Town, State
Baltimore,	permit. Pa Departmen Important: any injury once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License			rraine R	. Name an	d Addres	s of Facility	20/06 ral Ho	m a T		, Maryland
	Physician /Medical		23a. Part1. En/ r me diseas , or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	PNEUM	1MT H							SHG 212	Approximate Interval Between Onset and Death
8760,	ysicien and special sp	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	URINAL Due to (or as a	consequ	ence of):	INFE			ISEAS			
P.O. Box 68	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 DNo 9  Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3□	Ectopic pr					23d. Date of o	delivery Day Year
Records, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions cor	tributing to death bu	it not resu	lting in the ur	nderlying c	ause give	n in Part I.	23	e. Did tobac		to the cause of death?  Probably 4 Onknown
	hysician: The law his certificete has b I director, page 2 st	e Completed	25. Was case referred to medical						00 Plana 44	1	a. Was an autopsy performed Yes 20	prior t death	autopsy findings available o completion of cause of ? es 2/2/No
Division of Vital	iending Physician: eath. or: After this certifice the funeral director. I	ToB	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5  Pending 2  Accident investigation	ospital: 1 Inpatie 28a. Date of Injur (Month, Day	у	ER/Outpatien 28b. Time of Injury		8c. Injury Work	4 LINUISIII	g Home 5[	Residence	e 6 □Other (S)	pecify)
Divi	To the Hospital or Attending Phwitin 24 hours elter death. To the Funerel Director: After th completely filled in by the funeral	Il Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injubulding, etc	. (Specify)	)			e date and ol	City	or Town, S	tate)	Rural Route Number,
)	To the Hos within 24 h To the Fun completely	Medical	29b. Signature and title of certifier	ner: On the basis of and manner sta	examinati	on and/or inv	restigation	License	number	ccurred at th	e time, date	and place, and d	nth, Day, Year)
	Ý		30. Name and address of person who co	P., M.I	).	7601		R D	RIVE	TOWS	DN, MA	RYLAND	21204
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 20	32. registra	r's Signati	" A	Book	9					

	Funeral Director	er
Dalimore, mar years 212,000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Model Examine finant be multiled at once.	To Be Completed by Funeral Director
	Physician /Medical Examiner	3r
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical Examiner

	1	For State Registrar	State of Ma	aryland	-	artment of rtificate of		nd Mental F		ne No.2006	29839	
Physician /Medical	ı	Decedent's Name (First, Middle, La	•	an Ma	ason			2. Date of Month		Day Year 11, 2006	3. Time of Death 10:25 p M	
Examiner	ľ		e of Baltimore (			4b. City, Town,	Е	Baltimore	Diet		ltimore	
Funeral Director			1	9 (In yrs. Ias 73	Yrs.	Months Days		Min. (Month,	Day, Ye	iar) (	rthplace (State or Foreign Country) Vest Virginia	
or 28a-f show be notified at Director		10a. State 10b. County  Maryland	N/A	10c. City,	Town or Lo		Baltimore		10d. Insi			
23e or 2 Inthe n		10e. Street and Number 209 Edgewood Street				10f. Zip Code	21229		10g. Citizen of What Country? U.S.A.			
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Modical Examiner man be notified at ance.  To Be Completed by Funeral Director		11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕱 No		n? (Specify Yes or Puerto Rican, etc.	No-	14. Race - American Indian, Black, White, etc.  Specify: Black		
ygiene. ner than "natur it, ine Mudical Completed		15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		(Give	dent's Usual Occu kind of work done DO NOT use retir	e during most o	f working	165	O. Kind of Busines	s/Industry Home	
Mental Hyg arked other atic event, I To Be Co		12 17. Father's Name (First, Middle, Lasi William	McDowell				18. Mother's	Name (First, Mid		den Sumame) McDowell		
ealth and n 27 is m		19a. Informant's Name/Relationship Regina Bradby	(Type, Print)		20	9 Edgewoo		altimore, Mar		ity or Town, State, 21229	Zip Code)	
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bysician and majorism the buriat-transit majorism and maj		23a. Part Enter the disease, of conshock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as:  Due to (or as:  Due to (or as:	a conseque	INCE of):	result	., 0	om bu		S	Approximate Interval Between Onset and Death Z. 9 Od V	
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but Medical Certification: To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal d	leath 3	□Ectopic pregnan □ Other (specify)	су			23d. Date of de Month	olivery Day Year	
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this cert al direct		examiner?  Yes 2 No  27. Manner of Death	Hospital:		R/Outpatier	IL SEL DOA	ther: 4 🗆 Nurs		esidence		ecity) Assited	
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within 24 hou To the Fune completely fill		29b. Signature and little of certifier	and manner sta		+,	29c. Licer	nse number		29d.	Date signed (Mor	nth, Day, Year)	
X State		30. Name and address of person who will be a second of the	completed cause of d	6 1	rimb	Print) 1-11	CTL	ither:	He,	MDZ	12,2006	

Registrar

SEP 2 0 2006

Division of Vital Records, P.O.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 4GENIA /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Aug. 3, 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F 96 Months 511-10-0510 Kansas Director Usual Residence of Decedent 10c. City, Town or Location 28e-f ehow 10d. Inside City Limits the Medical Examiner must be nutified at Prince George's 1 ☐ Yes 2 X No Directo Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 8915 Ballard Lane 20735 U.S.A. Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed withIn 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No δ If Yes, Give Year or Dates: Yes, Give Specify: White Specify: 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home permit. Pages 1 and 2 should be filed Department of Heelih and Mental Hyg Important: If Item 27 is marked other eny injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Owen Kelly Bridgett Gormley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. McCall (Son) 1002 Spruce Street Waldorf, Maryland 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 23, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 2006 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician resulting in death) /Medical Pue to (or a consequence of). Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physicien: The law requiree that the death certificate be executed signed by the attending physicien and I be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes 1 🗆 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death Check only or Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 📉 No 1 npatient 2 ER/Outpatient 3□ DOA Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation death. To the Hospitel or Attendi within 24 hours after death To the Funersi Director: A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death promed at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 63 ted cause of death (Item 23a) (Type, Print) 15 Surratts Road Suite 208, Clinton, MD 20735 Dr Hammack, M.D. 7501 32. Registrar's Signature 31. Date filed (Month, Day, \*Pear) State Registrar 2 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 29841 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day September 13, **Physician** Janice Russell 2006 9:50a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthpface (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 ☐ M 200 F Yrs 579-52-5865 9/17/1940 Alabama Usual Residence of Decedent 10c. City, Town or Location 10d. fnside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☐ No VA Fairfax McLean Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1515 Great Falls Rd. #211 22101 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Marned 1 ☐ Yes 📆 No Specify: by 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Counselor Cemetery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melvin Duncan Russell Edith Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6132 Wicklow Dr., Burke, VA 22015 Thomas May 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 9/18/2006 Falls Church, VA 4 □Donation 5 □Other (Specify) 21. Signature of Francial ervice Licensee <sup>22</sup> Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final METASTATIC NON SMALL LUNG CANCINOMA disease or condition resutting in death) Due to (or as a consequence of) SMALL b. WON LUNG (mucen Due to (or as a consequence of)

Physician /Medical Examiner

**Funeral** 

Director

ir than "natural", or itama 23a or 28e-f show the Medical Evantinar must be notified at

12 should be filed within 7 n and Mental Hygiene.
7 Is marked other than \*r

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Department of Important: If sny injury or once.

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physician and s the burial-transit Exam Physiclan/Medical anding p been signed by the should be datached þ Completed page 2 s cartificate rector, Be ē မ After thi Certification: Director:

The law requires that the death certificate be

Records,

of Vital

Division

Attending Physician:

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

> IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> > 5 Pending

investigation

6 Could not be determined

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 4☐Pregnant at time of death 9 Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Due to (or as a consequence of)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an autopsy perform 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 1 Tes

Year

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Definer (Specify) Hessice

2 No

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Infury 1 ☐ Yes 2 ☐ No 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 -Naturaf

2 Accident

3 ☐ Suicide

29a. Certifie

Medica

4 Homicide

(Check only

porsician 10015135 29d. Date signed (Month, Day, Year) 09/12/2006

e of person who completed cause of death (ftem 23a) (Type, Print)

Phy). MD SHACKDY N. CHAMEES ST LSHOUL 6565 31. Date filed (Month, Pay: Year) 32. Registrar's Signature

State Registrar

within 24 hours aftar To the Funerel Dire

		•	For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of hartificate of	Health and <i>Death</i>	Mental Hy	/gien Reg. N		5 29842
ı	Physici	an	Decedent's Name (First, Middle     Don		McLaugh				2. Date of D Month	eath Da	ay Year 15, 200	3. Time of Death 6 3:30 P M
	/Medic Examin		4a. Facility Name (If not institution			7.111	4b. City, Town, o	or Location of Dea			c. County of Dea	
	L.Xaiiiiii	Ċ1	Woodside Center	Genesis	Elderc	are	Silver	Spring			Montgor	nery
	Funeral Director		5. Social Security Number 578-40-6460	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	. /ast birthday) Yrs.	If Under 1 Year Months Days			rth ay, Year y 3,	9. Bir Ci 1929 Wash	thplace (State or Foreign ountry) ington, D.C.
	pc ,		Usual Residence of Decedent		10- 0							
	ehov	2	10a. State 10b. County		100.0	ity, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
	the M	ecto	Maryland Montg  10e. Street and Number	omery		Kensin	gton 10f. Zip Code			10a. C	itizen of What C	
	3a or	Ö	3020 Fayette Ro	ad			2089	95		-	nited S	•
0	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene Item 27 Is marked other then "natural", or items 23s or 28s-1 show other traumatic event, its Mudical Extensions could be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marr  3 ※ Widowed 4 □ Divorced	Armed I led 1 Tyes If Yes, 0	2 X No Bive		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🎇 No	an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	encan Indian, le, etc. Vhite	
3	ture!	ed b	15. Decedent	's Education	Dates:	16a. Dece	dent's Usual Occu	pation		16b.	Kind of Business	/Industry
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7	hould d Men narke	은	Edward William  19a. Informant's Name/Relations			10h Maili	ng Address (Street					Zio Codol
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ה ה	os 1 and 2 of Health item 27 I	133	20a. Method of Disposition		20b.	Place of Dispo	esition (Name of matory or other pla		Date	_	Location - City or	
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	permit. Pages Department of I Importent: If its any Injury or of		21. Signature of Funeral Service	Consee	M013	a Ro	Name and Address bert A. Pui 57 Wiscons:	mphrey Fun	eral Home/ Bethesda.	Bethe Mary	esda-Chevy vland 2081	7 Chase, Inc. 4-3501
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			Meorge	-fli Xl	upe	ack	D.	12121		Sept	tember 1	8, 2006
	10		30. Name and address of person George F. Senga				Print) a Drive,	Wheaton	, Maryla	and	20906	
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Sign	nature	acks 9					
			CED 9 A	/IIIb 1 #7	Salah B .	5.3° AM	No. of Street, or other Persons and Person					

			•	State of Marylar	nd / De		nt of H	ealth and	Montal Hya	iono	29843
F	Physici	an	Hegistrar     Decedent's Name (First, Middle, Last)     Frances McDani	0.1		·	ile of L		2. Date of Deat	h	3. Time of Death 26 2645 AM
	/Medic Examin		4a. Facility Name (If not institution, give st Saint Joseph I		nter	4b. Cit	y, Town, or	Location of Dea		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 2 1 4 - 2 2 - 7 8 9 8	7. Age (In yrs. 7 9	last birtho	Month:	ler 1 Year s Days	If Under 24 Hr: Hours Min		9. Bir 927	thplace (State or Foreign ountry) N Y
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	be lied within 72 hours after death with the Marylan tal Hygiene. Ital Hygiene. d other then "naturel", or iteme 23a or 28a-1 ehow event, the Madical Examinar must be notified at	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1Yes _ 2\_No If Yes, Give Year or Dates:		13. Was Dec If Yes, sp	edent of Hi	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	te, etc.
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DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Diffector: Aft completely filled in by the fun	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - At h building, etc. (Special	fy)				City or Towr		
	ne Hosp in 24 hou he Funel pletely fil	Medicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Examine one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, d ation and/o	leath occurre or investigation	ed at the tim on, in my op	e, date and place inion, death occ	e, and due to the ca curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
,	To t Com	Σ	29b. Signature and title of certifier	hhim 1	11-1	) -  2	9c. License D26		2	9d. Date signed (Mod.	th, Day, Year)
	7		30. Name and address of person who com PEMY CHHIM, M. 1				E T	OWSON,	MARYLANI	21204	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 2006	32. Registrar's Sign	ature	and I					

Mc Gibney, Margaret
Baltimore, Maryland 21215-0036

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1
Box 68760,
P.O.
Records,
Vital
of
Division

		State of Maryland / Dep  1- State of Maryland / Dep		lealth and M	lental Hyg	
Physicia /Medic	ın al	Decedent's Name (First, Middle, Last)     Margaret Rebecca McGibney			2. Date of Deal	th Day Year 3. Time of Death
Examine		4a. Facility Name (If not institution, give street and number)  LONIEN OLE BUILDING  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Bel Air	Location of Death	8. Date of Birth	4c. County of Death  HARFORD  9. Birthplace (State or Foreign
Funeral Director		212-20-0712	Months Days	Hours Min.	(Month, Day, Aug. 13	, 1922 Pennsylvania
the Maryla 28a-f ehov	ector	Maryland Harford Joppa  10e. Street and Number	10f. Zip Code		11	10d. Inside City Limits 1 ☐ Yes 2 ☑ No  Og. Citizen of What Country?
h with	i Di	607 Magnolia Rd.	21085			USA
urs a	by Funer		3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
ithin 72 ho ne. nan "natur Madical	Completed	15. Decedent's Education (Specify only highest grade completed) (Gir Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occup ve kind of work done o DO NOT use retired	ation during most of worki	ing	16b. Kind of Business/Industry
led willed will have the		12 Home	emaker	18. Mother's Name	(First Middle	Own Home
d be f	To Be	Oral Robert Heaps		Sarah Ja		,
2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print) 19b. Ma		and Number or Rura	al Route Number	r, City or Town, State, Zip Code)
and 2 lealth m 27 i						land 21085
Pages 1 nent of H int: if its		1 ⊠Burial 2 □ Cremation 3 □ Removal from State cemetery, cr	position (Name of rematory or other place	e)		20c. Location - City or Town, State
artme ortani injury		21. Signature of Fureral Service Licensee	Memorial  22. Name and Addres	9-18 ss of Facil <u>i</u> ty		Bel Air, Maryland
Per Chap		23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	McComas Fu 1317 Coke	shury Rd	Abing	don Maryland 21009
bur bur	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if ally, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	NAL DISE	A 3E		Onset and Death
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medio		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delivery Month Day Year
quires that en signed t	þ	Part II. Other significant conditions contributing to death but not resulting in the  HYPOTHYROID, CORONARY ARTERY	, , ,	en in Part I.		bacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 20 Unknown
sician: The law re certificate has be rector, page 2 sho	Completed	HYPERTENSION, ATRIAL FIBRILLATION	V		24a. Was a autops perform	sy prior to completion of cause of med? death?
sician: certific rector.	Be	25. Was case referred to medical examiner?  Hospital:	ent 3 DOA Oth	26. Place of Deatl		
this ald	Certification; To	27. Manner of Death  1 Manuar of Death  1 Manuar of Death  28a. Date of Injury (Month, Day Year)  2 Accident  3 Suicide  6 Could not be determined of the de	of 28c. Injun Work	y at k? Yes 2 □No	28d. Describe he	ence 6 Other (Specify) ow injury occurred  treet and Number or Rural Route Number,
lospital or hours afte uneral Dir siy filled in	edical Cert	4  Homicide building, etc. (Specify)  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	eath occurred at the tin	ne, date and place,	and due to the c	ause(s) and manner as stated.
thin 24	Med	one) and manner stated.  29b. Signature and title of certifier	29c. Licens			29d. Date signed (Month, Day, Year)
7 × 50		Mulhayem MD		5344		09/14/06
5						
Sta Registra	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type SURESH DHANJAN) MD 622 S. U.  31. Date filed (Month, Day, Year) 32. Pegistrar's Signature SEP 2 0 2006	Jakes Jakes	r//YVKE I	ic ykni	L, 1-10 610/0

State of Maryland / Department of Health and Mental Hygiene, 29845 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 14, 2006 **Physician** THOMASINA MORRIS 8:45a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3500 COTTAGE AVE. BALTIMORE If Under 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 37 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min SOUTH CAROLINA 216-34-7315 1 □ M 2√□ F 68 Yrs. Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, if e Madical Examinations the notified at 1 ☑ Yes 2 ☐ No N/A BALTIMORE Funeral Director MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3500 COTTAGE AVE. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) -12-College (1-4or 5+) -2-DIETARY UNIVERSITY HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental ROSA WILSON THOMAS PORTER and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health a it: if item 27 is y or other train CLEVELAND MORRIS (HUSBAND) 3500 COTTAGE AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 K Buriai 2 □ Cr mation 3 □Removal from State Department of Important: If GARRISON FOREST VETERANS 9-22-2006 OWINGS MILLS, MD. injury ⁴ 4 □ Donation Other (Specify) D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fun rvice L 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 1 Yes 2 No 2 No 1 TYes or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home • Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year). 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 16 32. Registrar's Signature Dav. State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005

For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Michael Joseph McShane 1:11 a.m.M September 12, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia Howard 9111 Gold Amber Garth If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex/ 7. Age (In vrs. last birthday) **Funeral** Days 58 Yrs. 544-52-4496 Director February 4, 1948 Oregon Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h Count 28e-f show treumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 21045 U.S.A. 9111 Gold Amber Garth 238 death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 Meyes 2 □ No 19 If Yes, Give Year or Dates: 19 Itams 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be tiled within 72 hours after c Department of Health and Mental Hygiene. Importent: if Itam 27 is marked other than "natural", or Itam any Injury or other treumatic avent, the Mental Black, White, etc. 1 Never Married 2 Married 1968 Baltimore, Maryland 21215-0036 1□ Yes 2No Specify: Specify White δ 3 Widowed 4 Divorced 1998 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government College (1-4or 5+) 2 Elementary/Secondary (0-12) Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret Stanton Francis Carmony McShane 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9111 Gold Amber Garth Columbia, Maryland 21045 Mrs. Isabel McShane Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 Cremation 3 Removal from State 11/29/2006 Arlington, Virginia Donation 5 Other (Specify) Arlington National Cemeterly Jure of Fareral Service Lice 22. Name and Address of Facility Slack Funeral Home, P.A um Weller 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final CANCER- Met a Static DANCreati Physician disease or condition resulting in death) /Medical Due to ( as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes : After this certifical funeral director, r 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 🗖 No Certification; To 1 Yes 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a, Certifie 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 12, 2006 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause N. Charles St. Balto. Md Zizox 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2006 Registrar

MATHERIN

			1 = For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of <i>rtificate o</i>	Health an f Death	d Mental Hy	/giene Reg. No	2006	29848
	Physici /Medic		Decedent's Name (First, Middle, Las Sook Oh	1)				2. Date of D Month 09/18	Day		3. Time of Death 2:00 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give Holy Cross Hospita	1		Silver			Mor	. County of Death	
養人	Funeral Director		223 01 2000	7. Ag	90 Yrs.	Months Day		Hrs. 8. Date of B Min. (Month, C 05/06/	irth lay, Year) 1916	9. Birth Cour Korea	
	Maryland In a show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Howard		10c. City, Town or L Ellicott						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28s	al Director	10e. Street and Number 9626 Longview Driv	e		10f. Zip Code 21042	)		10g. Cit	tizen of What Cour Korea	ntry?
920	within 72 hours atter death with the Maryland ane. than "naturel", or items 23a or 28a-f show in Madical Exercitar I wat the rigilish at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 11 Yes, Give Year or Dates:		Was Decedent of If Yes, specify Control of Italyes 2√N	uban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: AS1	etc.
21215-0036	tiled within 72 he Hygiene. other than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use reti	ne during most of	working		ind of Business/In	dustry
Maryland	2 should be filed within and Mental Hygiene. Is marked other than saumatic event, If a Im.	To Be C	17. Father's Name (First, Middle, Last) Kwan Hyung Moon				Unknov				
a)	ss 1 and of Health item 27 other to		19a. Informant's Name/Relationship (7)  Jung Nam Oh / S  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	ON Removal from State	9626 20b. Place of Dispr cemetery, cre	Longview stition (Name of matory or other p	Drive,	Ellicott Date 09/22/06	City 20c. Lo	y, MD 210 ocation - City or To	042 own, State
Baltii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licent	500	Ga.	2. Name and Add	tress of Facility Nufman Fr	uneral Ho Blvd., El	me at	t MMP, II	NC.
	Physicien pe executed but sicien be executed but sicien and suppression in the private in the pr	dical Examiner	3a. Park Enter the lise in vircong book or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Clostri Due to (or as b. Due to (or as	the death. Do not enter.  Clium Diff: a consequence of): a consequence of):			diac or respiratory	arrest,		Approximate interval Between Onset and Death
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√□ No 9 ☐ Unknown.	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnar □ Other (specify)				23d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	_	ut not resulting in the u	inderlying cause	given in Part I.		_		he cause of death?
		Completed						24a. Wa auto pen 1 🗆 Yes		prior to co death?	opsy findings available impletion of cause of
Vital	Physician: The ribic certificate ral director, pag	Be	25. Was case referred to medical examiner?	lla acitali				Death Check only	one		
of	this c	၉	TE THE AL INO	Hospital: XX Inpatie		IL SU DOA		ng Home 5 ☐ Res			(y)
Division	tending leath. tor: After the fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	Year) Injury	M 1	☐Yes 2☐No			nd Number or Rura	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely tilled in by	edical Ce	2.5 Cartiliar 13 Certifying Phy (Check only one)	nsician: To the best iner: On the basis of and manner sta	I my knowledge doal examination and/or in ited.	conumed at the	time, data and p y opinion, death o	face, and due to the occurred at the time	cause(s) , date and	) and manner as ed d place, and due to	tateu. o the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier	I le	galu	ry D522	nse number			te signed (Month, 18/2006	Day, Year)
100	Sta	ate	30. Name and address of person who of Alan R. Segal, MD  31. Date filed (Month, Day, Year)	1500 Fo	eath (Item 23a) (Type, rest Glen ars Signature		.lver Sp	ring, MD	2091	0-1484	

				partment of Health and Me ertificate of Death	ental Hygien Reg. N	/ 11 11 kg	29849
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  38 km L PAPA 78 N ; 0 V  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month DE	ay Yeer 15 200 c. County of Deal	th
	Funeral Director		305 E. Joppa Road Apt 1204  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	B. Date of Birth (Month, Day, Year DEC. 26,1	9. Bird	thplace (State or Foreign punity)
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28e-f show other treumetic event, the Medical Evantice must be notified at	Direc	10a. State   10b. County   10c. City, Town or 10c. Street and Number   305 E. Joppa Road   Apt. 1204		10g. C	itizen of What Co	10d. Inside City Limits 1 □ Yes 2 1 No  puntry?
9500-9	2 hours after dea aturel', or Items	ted by Funeral	1 X Never Married 2 Married 1 X Yes 2 No If Yes, Give Viet Nam  15. Decedent's Education 16a. Dec	. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☑ No Specify: edent's Usual Occupation	16b.	14. Race - Ame Black, Whit Specify: W Kind of Business	e, etc. hite
Maryland 21215-0036	ould be filed within 77 Mental Hygiene. sarked other than "nietic event, It of Media	Be Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  2  Re  17. Father's Name (First, Middle, Last)	re kind of work done during most of working DO NOT use retired)  Staurant Manager  18. Mother's Name (	First, Middle, Maide		
e, Maryla	1 and 2 should Health and Men tem 27 Is marke other treumetic	٦	Carol Papatonious Sister-in-law 192	iling Address (Street and Number or Rural I 3 Wildwood Avenue position (Name of Dai	Baltimore		Zip Code) and 21234
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr Once.		1 Burial 2 Cramation 3 Hamoval from State 14 Donation 5 Cother (Specify) Entombment Parkwo	od Cemetery 9-19-2  22. Name and Address of Facility Ruck  1050 York Road To	2006 Pan K Towson F Owson, Man	uneral	Maryland Home, Inc. 21204
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence it):	nter the mode of dying, such as cardiac or in Antony Ossis.  MEILITUS			Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Cue to (ur as a consequence of).  C. Due to (or as a consequence of):	MEILIA			15 yns
P.O. Box 687	death certific e attending p od for use as t	Physician/Medio		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ive <i>ry</i> Day Year
	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes	No 3□Pi	o the cause of death? robably 4 □Unknown
Vital Records,	Physicien: The law this certificate has t ral director, page 2 s	Be Completed	25. Was case referred to medical examiner?	26. Place of Death (		prior to death? o 1 ☐ Yes	utopsy findings available completion of cause of
Division of	or Attending Physiter death.  Director: After this in by the funeral dil	Certification; To	1 Yes 2 No	of 28c. Injury at 28 Work?  M 1 Yes 2 No	5 SR Residence  Id. Describe how injuly  If. Location (Street a City or Town, Sta	ury occurred and Number or Ri	
_	To the Hospital within 24 hours a To the Funerel Completely filled	Medical C	29a. Certifier (Check only one)  1	investigation, in my opinion, death occurred 29c. License number	at the time, date ar	ate signed (Mont	h, Day, Year)
	2+1			e, Print) reene Street Bo	Sepi	tenha (mo	15, 2006
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 2006 32. Registrar's Signature	Speaks		1	

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			1 - For Stete Registrar	State of Ma	-	epartment of Certificate o			ene 9. No. 20 (	06 29850
	Observation		Decedent's Name (First, Middle, Last)			***		2. Date of Death	h	3. Time of Death
	Physici /Medic	al	Carl W. Radcliffe,			41 Ch T		Septembe		
	Examin	er	4a. Facility Name (If not institution, give s 11614 Manor Road	treet and number)		Glen A	n, or Location of Deat	n	4c. County of 1	
i	Funeral		Social Security Number     6. Sex		(In yrs. last birt	Months   Day			1 <sup>Y</sup> 844) 2	Birthplace (State or Foreign Country) Maryland
	Director		215-14-9596 12	M 2□F 8:	3	Yrs.		May 2,	1923	Maryland
	how	_	10a. State 10b. County		10c. City, Town					10d. Inside City Limits
	28a-1	Director	MD Baltimore		Glen A	↑M 10f. Zip Code	0	11	Og. Citizen of Wha	1 Yes 2 No
	within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow ha Modical Exardinar mail by mullied at	i Di	11614 Manor Road			21057	0		SA	a country.
	teme 2	Funerai	V	12. Was Decedent E Armed Forces?		13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
350	urs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □ N If Yes, Give Year or Dates:	0	1 □ Yes 2 □χ↑	No Specify:		Specify:	white
2-003p	72 hou		15. Decedent's Edui (Specify only highest grade		16a.	Decedent's Usual Oct (Give kind of work dot life. DO NOT use ret	cupation ne during most of wo	rking	16b. Kind of Busin	ess/Industry
Z	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	F)	<i>life. DO NOT use ret</i> dustrial E			Westingh	ouse
מ	e filed other vent,	0	17. Father's Name (First, Middle, Last)				<del></del>	mə (First, Middlə, A		
yland	should be ind Mental marked o	To B	Carl W. Radcliffe	·			Theresa			
=	es 1 and 2 should be filed of Health and Mental Hygi f flem 27 is marked other ir other treumatic event, [		19a. Informant's Name/Relationship (Ty) Helen Marie Radcl			. Mailing Address <i>(Stre</i> 614 Manor			•	ite, Zip Code)
ē,	is 1 and 2 of Health a ltem 27 is other tree		20a. Method of Disposition			Disposition (Name of y, crematory or other p			20c. Location - Cit	y or Town, State
Ē	Pege ment c ant: If ury or		1 Durial 2 Cremation 3 R 4 Donation Other (Specify)	emoval from State		the Evangeli:		L/06	Hydes, M	
Baltimore,	permit. Peges Department of H Important: If its eny injury or of		21. Signature of Furieral Service Lice	<b>*</b>		22. Name and Ad	dress of Facility Son Funera	1 Home		rk Road MD 21204
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	colons that caused	the death. Do r					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Car	rcino	id tum				Onset and Death  3 years
	/Medical Examiner		resulting in death)	Due to (or as a	consequence					
	ř	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as t	esiteupuariea	J):				
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D	consequence	- 10				
Ď,		a		Due to (or as a	Consequence	JI).				
280	leath certificate attending phys I for use as the	Aedic	IS SERVICE	•		-me	**************************************			
X Q Q	ath cer titendir or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of	2 Fetal death	3 □Ectopic pregna			23d. Date o Month	f delivery Day Year
o.	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death	5 ☐ Other (specify,	)			
S,	The law requires that the death certificate tite has been signed by the attending physicage 2 should be detached for use as the	by Physician/Medic	Part II. Other significant conditions cor	itributing to death bu	it not resulting in	the underlying cause	given in Part I.		~	ite to the cause of death?
ecords,	requir	eted	Diabeles me	111105	/			1 □ Ye	/1	☐ Probably 4 ☐Unknown
Hec	helaw ehast ge 2 s	Completed	Coronary a	rieryo	iseas	<u>e</u>		24a. Was a autops perform	y prio ned? dea	
Vital		BeCc	25. Was case referred to medical			tipali vito	26. Place of De	1 ☐ Yes 2 ath Check only on		Yes 2□ No
<b>&gt;</b>	= = =	၉	1 162 5 5 10	lospital: 1  Inpatier		tpatient 3 LI DOA		Home 5 Reside		(Specify)
00	ding f th. : After s funer	tion	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injur (Month, Day			njury at Work? □ Yes 2 □ No	28d. Jescribe no	w injury occurred	
DIVISION	r Atter er dea rector by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, fa . (Specify)	rm, street, factory, offi	се	28f. Location (St. City or Town		or Rural Route Number,
٥	pital o		29a. Certifier 1 Certifying Phys	riging. To the heat o	f my knowlodes	e, death occurred at the	- since along and along	and due to the ea		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifician completely filled in by the funeral director,	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination an	d/or investigation, in m	ny opinion, death occ	urred at the time, da	ate and place, and	of as stated.  If due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				ense number	2	9d. Date signed (	Month, Day, Year)
			May	- Act	) ():== ??=:		2556	7	09/1	8/06
	140		Trancis Wiegmann	MD. Z	205	Ort Rd.	#11/Lut.	kerville,	Md->	(093
	Sta Regist		31. Date filed (Month, Day, Year)	32. Fegistra	r's Signature	heale	/			
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Stat	e c	of N	Man	yland	<b>1</b> / b	)epar	tment	of	Health	and	Ment	al H	ygien	e 🚄	U	U	U	4	J

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 218 2006 Physician 6:15 p M Mary Mingon Robinson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Timonium Stella Maris If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Authorith, 23, Year 923 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖔 F 83 217-16-1084 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits marked other than "natural", or items 23s or 28s-f show imatic event, the Modical Examinar must be notified at 1 Yes 2X No Director Baltimore Sparks Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12 Glencoe Manor Court 21152 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: þ Baltimore, Maryland 21215-003 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plastics Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental Stinchicum Edward Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 shi Department of Health and Important: If Item 27 is m eny injury or other traum. 12 Glencoe Manor Ct. Sparks, Md. 21152 Judy Cullison/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State place) 1 ABurial 2 Cremation 3 Removal from State Dulaney Valley Mem. 9-21-06 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Leensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Septicemia Sequentially list conditions, it any leading to in a cliat, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or an a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown 1 Tes 2 No Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No page certificate Vital 1 ☐ Yes Be ( 25. Was case relerred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA MOSPICE this ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospitel or Attending s efter de. rai Director: Altr Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIA MAHMOOD 2306 Dulaney Valley Rd TIMONIUM, MO 21093 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

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Robinsor

MARY

State of Maryland / Department of Health and Mental Hygiene 2006 29852 For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nellie Dare Ricucci September 16, 2006 9:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville Year | If Under 24 Hrs. | Montgomery 8. Date of Birth (Month, Day, Yea January 24, If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year 1□M 2፟X F 577-22-0207 87 Yrs. 1919 Washington, D.C Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Maryland Montgomery Laytonsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21747 Mobley Farm Drive 20882 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, While, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married ☐Yes 2 X No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 Federal Government marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I Charles Curtley Lena Williams ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Bonavia / Grandson 21747 Mobley Farm Drive, Laytonsville, Maryland 20882 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₽ <u>=</u> ₽ September 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 20, 2006 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Sugafalte Barr M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Cardiomyopathy pue Due to (or as a consequence of): attending physicien for use as the burial P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f s been signed to should be deta Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes tirrector, page 2 s autopsy performed? Yes 2 🗓 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🔯 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Yo the recent within 24 hours after death.

To the Funerel Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D30132 September 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rica Ghosh, M.D. 14812 Physicians Lane, #161, Rockville, Maryland 20850 31. Date filed Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

		1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F			giene Reg. No. 20	06	29853
Physic	rian	Decedent's Name (First, Middle, Last)					2. Date of Dea		Year 3.	. Time of Death
/Med	ical	Michele Patrice  4a. Facility Name (If not institution, give		ds	Ab Cibi Tourn	r Location of Death	Depten		2006	2203 4
Exami	iner	Upper Chesapeake		Center	Bel Air		•	Harf		
Funera	1	5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti (Month, Day	h	9. Birthplace	(State or Foreign
Director		217-80-5350	]M 2 <b>]</b> ØF	46 Yrs.	Months Days	Hours Min.	Feb. 29		Baltir	nore
and		Usual Residence of Decedent  10a. State 10b. County	<del></del>	10c. City, Town or Lo	ocation				10d. I	Inside City Limits
(1215-0036 within 72 hours after death with the Maryland ene. than "natural; or iteme 23e or 28e-1 show to a Maryland to Maryland to Maryland Exercites must be notified at	ctor	Marvland Harford		Joppa						1 ☐ Yes 2½∑ No
vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
eath v	eral	223 Beechwood Ave	2. 12. Was Decedent	Ever in H.S. 13	21085 Was Decedent of H	lionania Origin? (Sa	and Van at Na	USA	- American Ir	ndion
fler d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	No	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		, White, etc.	iciaii,
-0036 2 hours after atural; or l	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:		1□Yes 🌪 No	Specify:		Specify:	Whit	te
2 h 2 h	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of work	ting	16b. Kind of Bu	siness/Industr	У
within 12	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use retired	d)		0		
C B B E		17. Father's Name (First, Middle, Last)		Home	maker	18. Mother's Nam	e (First, Middle,	Own Hor Maiden Sumame		
yland 212 yland 212 ould be filed with Mental Hygiene. arked other than	To Be	John (unk) Jubb				Patricia	a (unk)	Key		
S sh man	1	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Numbe	r, City or Town, S	State, Zip Coo	fe)
re, re tree tree tree tree tree		Raymond A. Reyno.	lds / Hus		Beechwood					
Profit History		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other plac		Date	20c. Location - (	City or Town,	State
Baltim Permit. Pag Department importment: any inlury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funferal Service License		Hilltop	Service C		5-06	Towson,	Maryla	and
O go go go go go go go go go go go go go		> Steple a	Muerty	2	McComas F 1317 Coke	uneral Hosbury Ro	ome, P.A ad, Abin	gdon, Ma	aryland	3 21009
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused le caust on each lin	the death. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory ari	rest,	Inte	proximate erval Between
Pnysician		Immediate Cause (Final disease or condition resulting in death)	- Kegn	Malores	Frelew	ف			1 7	set and Death
/Medical Examiner		resulting in dealth)	Due to (or s	a consequence of):	- be	2 . 1+ (	CANC	rc a	7.34	TWA B. D.
8	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	CIST	easi	LANC	73	UA	Kraun
outed ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events							15	
COHCO FGO, Lobe executed sicien and burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
25 g g g g	dlcai		l							
Box 6i Box etific	/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy						
Bo Beath leath etten	Physician/Me	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mon	of delivery th Day	Year
P.O. that the dot by the detached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown							
MICHEL M Records, P.O. Box 6 The law requires that the death certification is the base of the electron of the base of the electron of the second for use as	þ	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.		bacco use contri		1 .
Records, ne law requires to the specifies  Completed						1 U Y	es 2 No	3 Probably	4 Unknown	
Rec selaw	m ple						24a. Was a autop:	sy pr	fere autopsy frior to comple eath?	findings available tion of cause of
		05 111-						20 No 1	Yes 2	No
	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ent 2 ER/Outpatier	nt 3 DOA Oth	er: A D Number 14s			- (0 (1)	
	n: To	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time o		- Indiang in		ence 6 Othe		
Vision Attending r death.	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y Year) Injury		Yes 2 □ No				
DIVIS I or Att after de Directed	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural Ro	ute Number,
Hospitel of Hours a Funeral C	2	29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge, deat	b accuracy at the time			(-)		
H A P P P P P P P P P P P P P P P P P P	edical	(Check only 2 Medical Exeminations)	ner: On the basis of and manner sta	examination and/or in	vestigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, c	ause(s) and mar late and place, a	ner as stated nd due to the	cause(s)
To the within 2 To the complet	₹ E	29b. Signature and title of certifier		Δ	29c. License		ž	9d. Date signed	(Month, Day,	Year)
		Phillicea	Que	mi	1020	6341	5	EFEMI	3ER 12	1,2006
10		30 Name and address of person who co	mpleter caus of	eath (Item 23a) (Type,	Print)	634A DICAL CE	4 176 10	LCIN:	a m	Aren A
٧	tate	31. Date filed (Morith, Day, Year)		ar's Signature	1 NC 1/15!	JICHL CE	NICK	15641	10, 111	MAMINE
Regis	tate trar	CED O 0 200		10	Ball 5					

				1 - State	State of I	viaryiai		rtificate of		Mental Hyg	eg. No. 2006	29854
				Registrar  1. Decedent's Name (First, Middle, La	ast)			runcate or	Doutin	2. Date of Deat		3. Time of Death
-		Physicia		Edward Evancia	Dafter					Septemb	er 12, 200	6 1:40 p M
	-	/Medic Examin		Fdward Francis 4a. Facility Name (If not institution, given		er)		4b. City, Town, o	or Location of Death		4c. County of Dea	
				8 Shannon Driv	re.			Be1	Air		Harfo	ord
		Funeral		5. Social Security Number 6.		Age (In yrs.	last birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day,	(Year) 9. Bir	rthplace (State or Foreign ountry)
		Director		192-14-2989	TLZXW ZLIF	_83_	Yrs.			May 26,	1923 Per	nsylvania
		land bw		Usual Residence of Decedent  10a. State 10b. County		10c. C	ty, Town or Lo	ocation				10d. Inside City Limits
		death with the Maryland ms 23a or 28e-f show rmust be notified at	tor	Maryland Harford	1	B.C	al Air					1 XYes 2 ☐ No
		h the	Director	10e. Street and Number			T ALL	10f. Zip Code		1	0g. Citizen of What C	ountry?
-		th wit		8 Shannon Drive				21014			USA	
b		ems	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	J.S. 13.	Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No-	14. Race - Am Bleck, Whi	
4	36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give	□ No		1 ☐ Yes 2 € No			Specify:	
Rafte	215-0036	tural	ed b	15. Decedent's E	Year or Date	s: WWII		edent's Usual Occu	nation		16b. Kind of Business	11te
$\propto$	215	in 72 n "na Medik	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4	or E ()	(Give		during most of work	king		,
	212	d with giene er the	mo:	Elementary/Secondary (0-12)	4	O( 3+)	Mathe	matician			Dept. of I	efense
	pu	al Hy d other	Be (	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam			
_	yla	ould b Ment arked	To	James Timothy Raf					·	nmn) Mul		
5	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship			1				r, City or Town, State, Maryland 2	
dwar	e,	1 and Healtl em 2 ther 1		Kathleen Cubbage  20a. Method of Disposition	/ Daugnte						20c. Location - City or	
3	nor	ages nt of t: ff it		1 Burial 2 Cremation 3		11(19)		osition (Name of omatory or other pla	- I			
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	Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or  c. Due to (or  d. 23c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow  contributing to deat  Hospital: 1 Inp 28a. Date of (Month, on be (Month, on be 28e. Place of building	as a consection of pregnant 2 Fet at at time of a state of the state o	ancy al death 3 [death 5 [death 6 [deat	Dotter (specify)  anderlying cause given to a specific pregnance given to the cause given to the course of the occurred at the three tigation, in my cause given to the course of the course of the cause of the c	ven in Part I.  26. Place of Deather: 4 \( \text{Nursing Horizott?} \)  Yes 2 \( \text{No} \)  Imp, date and place, opinion, death occur se number	24a. Was a autops perform 1 Yes :  th (Check only on ome 5 Peside 28d. Describe how the carried at the time, described as the time, described to the carried at the time, described to the carried to the carried at the time, described to the carried to the carried to the carried at the time, described to the carried to the	Month  bacco use contribute t es 2 No 3 P en prior to death? 2 No 1 Yes ence 6 Other (Spe ow injury occurred  backer and Number or R n, State)  ause(s) and manner a ate and place, and du  9d. Date signed (Mon.)	o the cause of death?  robably 4 faUnknown  utopsy findings available completion of cause of s 2 fd No  acify)  fural Route Number,  s stated, e to the cause(s)  th, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Amend item#10e,19b,perFH,C859,9/29/00 CErtificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** e otember 1 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) timo If Under 24 Hrs. 8. Date of Birth (Month, Day, July 11 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🖫 F 484-50-8274 65 Director Iowa Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "najural", or items 23s or 28s-1 show other traumatic event, the Medical Exercitant must be notified at 10d. Inside City Limits Maryland 1 ☐ Yes 2 ☑No Howard Fulton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7349 Pindell School Road 9537 Pindell School Road 20759 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ie marked ပ္ Charles Brower Grace Robinson 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: if Item 27 io Pindell School Road Fulton, MD 20759 John Semonco (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State permit. Pages Department of Important: If It eny injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) Ft. Lincoln Cemetery 9-21-2006 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Ho 5555 Twin Knolls ome, Inc. Road Columbia, MD 21045 23a. Part1. Enter the dise is shock, or heart failur. mions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or Examiner signed by the attending physicien and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2▼ No 24a. Was an this certificete has 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Alatural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attanding 5 Pending death. investigation 1 ☐ Yes 2 ☐ No filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital of within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature ar 29c. License number use of death (Item 23a) (Type, Print) 600 North wolfe St. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 0 2006

			1 - For State Registrag	State of Ma	ryland / De	epartment of F Certificate of	Health and I	Mental Hygi	•	6 29857
ì	Physici /Medic Examir	al	1. Decedent Name (First, Middle, La.  A. Fecility Name (If not institution, giv Genesis Long Gre	277 e street and number)	Sut		or Location of Death	2. Date of Death Month	Day Year 200	3. Time of Death 23 4 Au
	Funeral Director		Social Security Number 6. S		(In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Feb 22	9. Bir (C) (D) (D) (D) (D)	thplace (State or Foreign ountry)
	death with the Maryland ms 23a or 28a-f show criust be notified at	Director	Md Somerse  10e. Street and Number 30564 Creekview		10c. City, Town of Princes			10	g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No ountry?
0036	hin 72 hours after death with the Marylar s. Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	iver in U.S.	13. Was Decedent of Hif Yes, specify Cub		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
70-CLZ1Z	d within 72 hou giene. er then "nature , the Wedical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation		ecedent's Usual Occup live kind of work done 'e. DO NOT use retire ETUCK driv			6b. Kind of Business	
aryland	should be file nd Mental Hy marked oth matic event	To Be (	17. Father's Name (First, Middle, Last) George Sutton  19a. Informant's Name/Relationship (	Type, Print)		ailing Address (Street	Jane		Voodward City or Town, State,	
nore, ma	ages 1 and 2 nt of Health a i: If Itam 27 Is r or other trau		Mrs. Jane Sutton  20a. Method of Disposition  1 Burial 2 Cremation 3	(mother)  Removal from State	20b. Place of D	5 Vincenza  sposition (Name of crematory or other plainty  ty Cremat:	сө)	Date 2	oc. Location - City or kesville,	Town, State
Daith	permit. P Depertme Importan any Injuri		4 □ Donation 5 □ Other (Specification of Funeral Service Licer  Programmed Transport of Funeral Service Licer	Herbert		P.O. Box	ess of FacilityHai 195 Sykes	ght Funer	al Home & 21784	Chapel
/oo/	eath certificate be executed Medical Medical Examiner and Fransit for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in dealh)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a C.	consequence of conseq	arr	my tru	ras	donce	Approximate Interval Between Onset and Death  Long  Marie
×	the death certifical y the ettending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1∐Live birth 2 4∐Pregnant at ti 9∐Unknown	Fetal death	3 □Ectopic pregnance 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
ecords, r	To the Hospitel or Attending Physician: The law requires that the death within 24 hours eiter death. Within 25 hours eiter death. To the Euneral Director: After this certificate has been signed by the etter completely filled in by the funeral director, page 2 should be detached for u	Completed by Pl	Part II. Other significant conditions of the control of the contro	ontribuling to death but On err Nou - C	t not resulting in the	e underlying cause giv	ren in Part I.		s 2 □ No 3 □ P	o the cause of death?  robably 4 _Unknown  ulopsy findings available completion of cause of
Vital H	ician: The certificete h ector, page	Be	25. Was case referred to medical examiner?	Hospital:		0 <u> 00</u> 0t		perform 1 ☐ Yes 2, th (Check only one	ed? death? No 1 \( \sum Yes \)	2 No
Division of	or the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by	28a. Date of Injury (Month, Day	Year) Inju	e of 28c. Injury	4 Nursing H	28d. Describe how	nce 6 Other (Spe winjury occurred seet and Number or R	
2	Hospitel or A 14 hours efter Funeral Directely filled in by		(Check only 2   Medical Exam	building, etc. ysicien: To the best of niner: On the basis of e	(Specify)  f my knowledge, dexamination and/o	eath occurred at the to	me, date and place	City or Town,	State)	hetets 2
•	To the To the complete	Medical	29b. Signature and title of certifier	and manner state	ed.	29c. Licens			d. Date signed (Mont	
	5		30. Name and address of person who 7505 054	er Di	2	TOWSON	, ME	212	04	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 <b>0</b> 2006	32. Registrar	r's Signature	w				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month SEPTEMBER 9. SAMUEL STARKS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROLAND PARK MANORCARE CENTER BALTIMORE N/A ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 MM 2 ☐ F Director 228-30-0430 80 10-30-1925 NORTH CAROLINA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene sent: If Item 27 is marked other than "naturel; or Items 23a or 28a-f ehow ury or other traumatic event, the Medical Examinar must be notified at 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1 XYes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1535 STONEWOOD RD. 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ □ No δ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) LABORER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 SAMUEL STARKS MINNIE DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EARLEAN STARKS (WIFE) 1535 STONEWOOD RD. BALTIMORE, MARYLAND 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ 3 Removal from State permit. Page Department of Importent: If any injury or once. 4 Donation Other (Specify) ELAMS UCC CEMETERY 9-16-2006 LITTLETON. NC 21. Signature of Fyneral JONATHAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INTESTINAL OBSTRUCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the aid to be detached for 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 hrimERS DEMENTIA 1 Yes 2 No 3 Probably 4 Minknown bleen si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b lirector, page 2 s 1 Yes 2 100 or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059107 ~ m.D 09-11-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 UMA BUSINESS CENTER DAVE REIXTERSTOWN MD 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 0 2006 (carde) Registrar

	1 - For State Registrar		d / Departmei <i>Certifica</i>	te of Death		Reg. No. 200	
Physician	1. Decedent's Name (First, Middle, Last)	Terry			2. Date of D Month	eath Day Yea	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give s		4b. City	y, Town, or Location		4c. County of De	<del>-</del>
	OAK CRE		$\mathcal{B}$	ALTIM	ore	Balti	
uneral irector	5. Social Security Number 208-16-5340 6. Security Number 1	7. Age (In yrs. It	Yrs. Months	er 1 Year   If Under B Days Hours	Min. Feb. 5	<sup>9. 1</sup> 1924 F	Birthplace (State or Foreign Country) Ennsylvania
-f show fied at tor	10a. State 10b. County Md. Baltimore		r, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 💆 No
at be notified	10e. Street and Number 8832 Walther Blvd	. #129		ip Code 21234		10g. Citizen of What	
importent: If item 27 is marked other then "neturel", or items 23e or 28s-1 show any injury or other traumatic event, the Madical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. Was Dece If Yes, spi 1 \( \subseteq Yes		gin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Race - A Black, W Specify:	merican Indian, hite, etc. White
t. the Medical E	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College_(1-4or 5+)	16a. Decedent's Usi (Give kind of w life. DO NOT			16b. Kind of Busine	•
Con		5	Guidance	Counselor		Education	n
natic even	17. Father's Name (First, Middle, Last)  Carl R. Terry			M	er's Name (First, Middle lyra V. Law	lor	
er traum	19a. Informant's Name/Relationship (Ty) Mr. Jeffrey Kane/				er or Rural Route Numb ne Elizabe		
or oth	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	ace of Disposition (Nametery, crematory or	ame of other place)	Date	20c. Location - City	or Town, State
njury o	4 □ Donation, 5 □ Other (Specify)  21. Signature of Funeral Service License	Hil	1top Servi		9-19-06	Towson,	Md.
any any	21. Signature of Pulledal Service Coensi	5	Ruck	Towson F	uneral Home Towson, Mo	Inc.	
WEE .	23a. Part1. En er the disease, 'r compli shock, or heart failure. List only or	cations that caused the death					Approximate Interval Between
ician	Immediate Cause (Final disease or condition resulting in death)	metast	atic	Ovario	an con	ICET	Onset and Death
dical iiner		Due to (or as a consequ	vence of):				
Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ianes of).				
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	:					
ical Examin	rosuling in deathy East	Due to (or as a consequ	ience of):				
edic							1
y Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnat 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic			23d. Date of o Month	delivery Day Year
p S	Part II. Other significant conditions con	ntributing to death but not resu	Ilting in the underlying	cause given in Part I		-	to the cause of death?  Probably 4 □Unknown
page 2 should I					24a. Wa	s an 24b. Were	autopsy findings available to completion of cause of
Page					auto perf 1 ☐ Yes	ormed? _ death	es 2 No
rector, page 2 s	25. Was case referred to medical examiner?	lospital:		Lau	of Death Check only		
aral dire	1 Yes 2 No  27. Manner of Death	28a. Date of Injury		28c. Injury at Work?	irsing Home 5 Res	how injury occurred	pecify)
e fune	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐	No	. ,	
ed in by the funera	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ery, office	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
completely filled in by the funeral director.  Medical Certification: To Be C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred ion and/or investigatio	d at the time, date ar on, in my opinion, dea	nd place, and due to the other than the time	cause(s) and manner , date and place, and d	as stated. lue to the cause(s)
To the Funeral Director: completely filled in by the Medical Certificat	29b. Signature and title of certifier		29	9c. License number		29d. Date signed (Mo	onth, Day, Year)
	a mo	Con		558646		Septemb	05 18 2006
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State of Maryland / Department of Health and Mental Hygiene 2006 29860 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 15, 2006 7:30 A Margie G. Toman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Director 79 228**-**26**-**7087 Virginia Usual Residence of Decedent the Maryland 10a State 10c. City Town or Location 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 ie marked other then "natural", or iteme 23a or 28a-1 ehov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 No Director Maryland Montgomery Wheaton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 4011 Highview Drive 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Austin L. Harris Carmon E. Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 8737 Kelso Terraçe, Gaithersburg, Maryland 20877 James R. Toman/Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 21, Department of important: if it any injury or conce. 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 Cemetery 22. Nime and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral S wice Licensee M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis Weeks /Medical Due to (or as a consequence of): Examiner Respiratory Failure
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Weeks Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia Weeks Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown s been signed b should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Inter-stitial Pulmonary Fibrosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus page 2 s autopsy performed? certificete 1 ☐ Yes 2√€ No 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No ဥ After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: , 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide filled in I 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D32332 September 15, 2006 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D. 9801 Georgia Avenue, Silver Spring, Maryland 20902 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 0 2006 California . Registrar

#### Please Type or Print in Black Indelible Ink

avid M. Triplett	State of Maryland / Department  1- For State Certificate Registrar	of Death	Reg. No. 2006 2006
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	ath Sa. Whe of Death O Day Year 1830 hrs
ledical Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
·	1622 Parkman Avenue  5 Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore  /) If Under 1 Year   If Under 24Hrs   8 Date of B	irth(MM/DD/YYYY) 9 Birthplace (State or
Funeral Director	215-84-4655 <sub>1</sub> X <sub>M 2</sub> 35	1	-1971 Foreign Country MD
any	Usual Residence of Decedent  10a State 10b. County 10c. City, Town or L		10d Inside City Limits
Maryland 28a-f show 1 at once.	MD Baltim	ore City	1 X Yes 2 No
the Natified	l L	21224	USA
or items 23	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
s after de ral", or aincr mu	Widowed 4 Divorced if tes, give real or Dates:	Yes 2 X No specify	Specify White
2 hours		edent's Usual Occupation (Give kind of work doneing most of working life DO NOT use retired)	16b. Kind of Business/Industry
21215-0036 uld be filed within 72 hour Mental Hygiene marked other than "natt c event, the Medical Exa	9 Ca	rpet Installer	Carpentry
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	5   17. Takilor 5 Hallis (Filos, Minasio, Essay	Mary Bavis	walden Surname)
2121 hould be find Mental I is marked attice event,	19a Informant's Name/Relationship (Type, Print )	ailing Address (Street and Number or Rural Route Nu 5 S. Lehigh St., Balt	
M 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2	20a Method of Disposition 20b Place of Di	sposition (Name of cemetery, Date	20c. Location - City or Town, State
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Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr	21. Signature of Funeral Service Licensee	22. Name and Address of Facility $Bra$ $ey-P.A.$ , $2134$ $Willow$ $Sp$	
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.		
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	n	Death
	Sequentially list conditions, b.		
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
nd nd ransit			
60, are be executed hysician and e burial - transit	Xunpended AMENDED item#23a,27,28	a-f,perME,G859,9/26/06 TT	
876( rtificate ing phy as the b	FEMALE:   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1	Fetal death 3 Ectopic pregnancy	23d Date of delivery  Month Day Year
Box 6876: death certificate the attending physele for use as the beath	AMENDED  IF FEMALE: 23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  AMENDED  1 ten#23a, 27, 28  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Other (Specify)	
that the d	Part II. Other significant conditions contributing to death but not resulting in	and and onlying datase giran in the	tobacco use contribute to the cause of death?  es 2 No 3 Probably 4 V Unknown
ords, P.C			s an   24b. Were autopsy findings available
COrc e law re re has be	Completed	per	opsy prior to completion of cause of formed? death?  1 Yes 2 No
Vital Recysician: The linis certificate	25 Was case referred to medical	26.Place of Death (Check only one)	
Division of Vital Records, P.O ral or Attending Physician: The law requires that it is after death.  "al Director: After this certificate has been signed by the funeral director, page 2 should be detacted.	O 1 Yes 2 No Repaired 28a Date of Injury 28b. Tim	atient 3 DOA Other Mursing Home 5 le of Injury 28c Injury at Work? 28d Describ	Residence 6 V Other: Scene e how injury occurred
ion C tending eath tor: Af the fun	1 Natural 5 Pending Fnd 9/10/2006 Fnd	5:20 pm <sup>1 Yes 2</sup> X No unknow	
Division pital or Attent ours after death neral Director: filled in by the	3 Suicide 6 X Could not be determined (Specify) ather-resid	or Town	(Street and Number or Rural Route Number, City State) 1622 Parkman Avenue
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To the Hos within 24 h To the Fur	(Check only one)  2 Medical Examiner: On the basis of examination and/or inversely and manner stated.  29b Signature and title of certifier	estigation, in my opinion, death occurred at the time, da  29c. License number	29d Date signed (Month, Day, Year)
	Id yela A.	O.C.M.E.	September 11, 2006
	30. Name and address of person who o impleted cause of death (Item 23a)  Zabiutlah Ali M.D. Assistant Modical Evaminar 111	Penn Street, Baltimore, MD 21201	
Sta			
Registr	- 000 WALL CA CARE		

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nonth Day Year September 15, 2006 8:45 a. **Doris Stromberg Thompson** /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll Fairhayen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 212-20-41018 Yrs. Director 82 July 28, 1924 Maryland Usual Residence of Decedent 10a. State 10b. County ?7 is marked other then "natural", or iteme 23a or 28a-f ehow traumatic event, the Moulcal Exeminar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Sykesville Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21784 Funeral 7200 3rd Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 end 2 should ba filed within 72 hours after nent of Heelth and Mental Hygiene. nent of Heelth and Mental Hygiene. ant: If item 27 is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Newspaper Publishing Elementary/Secondary (0-12) College (1-4or 5+) Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LaRue Radcliffe ပ Paul Griffith Stromberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Heelth a Important: if item 27 is eny injury or other trai once. 3788 Church Rd. Ellicott City, Maryland 21043 Daughter Ms. Ann Hogg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ellicott City, MD 09/19/2006 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that based the shock, or heart failure. List only one cause on each line. or complications that daised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Multic Immediate Cause (Final disease or condition resulting in death) Aspiration

Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law raquires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2. No Year Month Day 5 Other (specify) ad by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cerebroruscular certificete 1∐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner?

12. Yes 2 \( \text{No} \) No 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 9-15-2006 8:25AM OGC within 24 hours after death.
To the Funerel Director: Asp:rution 2 Accident 1 Tyes 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide rence pellil Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 34849 30. Name and address of person who completed cause of death (Item 23a) (Typ., P. nt) Rd & Klesbuz MD 21784 Liberty William lan MD 32. sistrar's Signature 31. Date filed (Month, Day, Year) State 2006 2 0 Registrar

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State of Maryland / Department of H	Health and Mental Hygiene 🖰 🖰 🖰

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	ith the	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?
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980	within 72 hours after death with the Maryland jiene. r then "naturel", or Iteme 23a or 28a-1 ehow the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes			s Decedent of Hes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)	)- 	14. Race - Ame Black, White Specify:	
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Ma	ges 1 and 2 should t of Health and Men if frem 27 is marks or other treumatic	l	19a. Informant's Name/Relationship (Ty) Paul Vrabel / spo	oe, Printi) Duse			radlero	a <i>nd N</i> um <i>ber or A</i> u ck Wav			or Town, State, 2 bia, MD	(ip Code) 21045
e,	s 1 ar if Hea item (		20a. Method of Disposition	·	20b. Place of	Disposition			Date		ocation - City or	
Ē	Pa Pa		1 ☐ Burial 2 ☐ ☐ Germation 3 ☐ R-4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			el Crem		2/2006	Ođ	enton, M	Maryland
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Division of Vital Records,	s law requir nas been si e 2 should l	Completed	Resp	iraton.	falue	2			24a. Was	psy	prior to c	lopsy findings available ompletion of cause of
al H			Stee	papn	ear'				perfo 1 ☐ Yes	2521No	death?	2 □ No
Ž	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	t 2 ER/Out		3□ DOA Othe	26. Place of Dea		-	а Пон /о	
J Of	ding Phys n. Atter this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Ti		28c, Injun	/ at	28d. Describe		6 □Other (Spec iry occurred	iry)
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a Certifier 1 Certifying Physics (Check only one)	er: On the basis of e	examination and	dawn oc or invest	coursed at the tin tigation, in my of	ne date and place pinion, death occu	t, and due to the irred at the time,	causa(s date an	d place, and due	stated. to the cause(s)
	To the Within To the Pomple	Me	29b. Signature and title of certifier	220			29c. License	e number		29d. Da	ate signed (Month	, Day, Year)
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	12		30. Name and address of person who con SU 2000 Abdo	mpleted cause of dea	ath (Item 23a) (T	ype, Prir	l'ane	Clar	lesul	le	MD de	8 <sup>Th</sup> 2006
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			For State	State of Marylan	id / Departm <i>Certifii</i>	ent of Health cate of Death	and Mental H		06 29861
			Registrar  1. Decedent's Name (First, Middle, Last	)	Oortine	il 1	2. Date of Month	Reg. No.  Death  Day  Yes	3. Time of Death
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1	Examin	er	4a. Facility Name (If not institution, give	Street and number)	0:12/ 3	A + MXE	of Death	4c. County of D	eath
	Funeral		5. Social Security Number 6. Se			Inder 1 Year If Under	7 24 Hrs. 8. Date of	Righ 9	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	™ 2×1 76	Yrs.	and Bayo Modele	March	Daz 9°, 1930	Greece
	yland		10a. State 10b. County	10c. Cit	y, Town or Location	1			10d. Inside City Limits
	Be-f	ctor	Md. Baltimo	re G1	en Arm				1 ☐ Yes 2 ☑ No
	3a or 2	I Dire	10e. Street and Number 12811 Ponderosa	Lane	10	f. Zip Code 2105 <b>7</b>		10g. Citizen of What	USA
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show important: if item 27 is marked other than "natural", or items 23a or 28e-f show important: if items 23a or 28e-f show in particular in the motilised at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	Decedent of Hispanic On specify Cuban, Mexica es 2 No Specify		Black, W	merican Indian, /hite, etc. /hite
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Mai	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mental management.		19a. Informant's Name/Relationship (T) Mr. Tasos L. Valar					nber, City or Town, Stat Arm, Md. 2	
ore,	of Hea		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ f		Place of Disposition cemetery, cremator	or other place)	Date	20c. Location - City	or Town, State
Baltimore,	Page tment tant: If		4 □Donation 5 □Other (Specify,	П	11top Ser	1	9-15-06	Towson,	Md.
Ba	permit. Pages 1 Department of F Important: If Ite any injury or ot once.		21. Signature of Juneral Service Licent	gle	22. Na	Ruck Towson OSO YORK R	d. Towson,	oma: 11204	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat ne cause on each line.	th. Do not enter the	mode of dying, such as	s cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
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Records,	w require s been sign should b	Completed					24a. W	has an 24b. Were	autopsy findings available
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ion	Attending Physician: r death. ector: After this certifici by the funeral director.	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury N		]No		
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	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knoiner: On the basis of examina and manner stated.	owledge, death occ ation and/or investig	urred at the time, date a lation, in my opinion, de	and place, and due to the time	he cause(s) and manne ne, date and place, and	r as stated. due to the cause(s)
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	/			~, 40	210-	RES-600	>	SEPTEMOS	R 13, 2006
	5		30. Name and address of person who c	ompleted cause of death (Iter Klebanaff (100	m 23a) (Type, Print	at Ball	WARS ALA	septemos	787
ď	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	A I MAIL	1140/114	417161 51	7/

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of Health rtificate of Deat	n and Mental Hy Th	ygiene 2006	29865
	Physici /Medi		1. Decedent's Name (First, Midd Annie Pauli				2. Date of D Month Septem	Day Your	3. Time of Death 8:45p M
	Examir		4a. Fecility Name (If not institution Stella Maris H	•	7)	4b. City, Town, or Location Timonium	on of Death	4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 218-28-6542	6. Sex 7. A 1	ge (In yrs. last birthday,  Yrs.	Months Days Hour	ler 24 Hrs. 8. Date of B s Min. (Month, D Oct 21	irth 9. Birth 2ay, Year) VA	place (State or Foreign Intry)
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County Md Carro		10c. City, Town or L Taneytow				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	<b>Funeral Director</b>	10e. Street and Number 3095 Benjamin	Drive		10f. Zip Code 21787		10g. Citizen of What Cou	intry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinar must be inclined at ODGE.		11. Marital Status  1 □ Never Married 2 ☒ Mar  3 □ Widowed 4 □ Divorced	If Yes Give	No	Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 【No Spec		14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	d within 72 ho piene. r than "natur the Medical.	Completed by	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4or	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired) UOT STORE OWI		16b. Kind of Business/I	
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	and 2 sho ealth and I m 27 is mu		19a. Informant's Name/Relation: Michael L. Polk		1578	ng Address (Street and Num Brimfield Cig	jrcle, Sykes	ville, MD 21	784
Baltimore,	t. Pages 1 rtment of H rtant: If Its		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☒ Other (5)	Specify)entombme	nt Loudon P	matory or other place) ark Maus.	9-21-06	Baltimore,	MD
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	Physician /Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	aLUNG	ed the death. Do not en line.  CANCER s a consequence of):	ter the mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G	s a consequence of): s a consequence of):				
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Division o	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Ir	njury - At home, farm, st	Work? M 1 ☐ Yes 2	□No 28f. Location	how injury occurred (Street and Number or Rui	al Route Number,
ā	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in I	cal Cert	29a. Certifier 1 Certifyi	ng Physician: To the bes	t of my knowledge, deat	h occurred at the time, date vestigation, in my opinion, o	and place, and due to the	own, State)  cause(s) and manner as	stated.
	To the h within 24 To the F complete	Medical	29b. Signature and title of certific	and manner s	stated.	29c. License numbe		29d. Date signed (Month	
	٨.		20 Name and adding	- who completed	double (lane 22-) 77	D437	25	9/18/0	16
	1,		30. Name and address of person  DR. TARIQ MAH	MOOD 2300 I	DULANEY VAL		NIUM, MD 210	093	
	Sta Registr		31. Date filed (Month, Day, Year, SEP 2, 0 20	32. Regis	trar's Signature	e e			

DHMH 17 Rev 1/2001

8:45 p.m.

SEPTEMBER 16, 2006

ANNIE VAIN

Amend Item 4a, 21 per DVR/SA, G859, 09/20/06dbb 2 Red. No. 2 006 29866 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ٥٥٥ Month Physician an June Woodard /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Overlea Health & Rehab Ctr. **Baltimore** If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months 1 □ M 2 🕱 F 411-32-7226 Yrs June 20.1925 Director 81 Washington DC Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mentel Hygiene. Int: If Itam 27 is marked other than "natural", or Items 23s or 28s-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tam 27 is marked other than "natural", or items 23a or 28a-f sho other traumstic event, the Medical Examinar must be notified at 1 Yes 2 □ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 6116 Belair Road 21206 USA Funerai 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black à 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk Kitchen Helper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk **Thomas** Woodard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Overlea Health & Rehab 6116 Belair Road, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🙀 Other (Specify) 21. Signature of Funeral Service Licensee per DVR 22. Name and Address of Facility State Anatomy Board,655 W. Baltimore Street Baltimore,MD 21201 Ronald S. Wade, Director 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CAP-DIOVASCULAR DISTA SE ATHEROSCIEROTIC Examiner Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician end for use es the bunel-trans Due to (or as a consequence of) Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s W No 1 ☐ Yes 1 ☐ No 1 Yes certificate Division of Vital To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 R No 1 ☐ Yes 2 ER/Outpatient 3 DOA this After this funerel 27 Menn of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation i Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours e To the Funeral C completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edicai (Check only 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEARAN , BATIMORE 2026 MANA NORTH 831 - FUTAW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 0 2006 Hegistrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 29867 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBERDA13, 20006 7:03P HERBERT WEEKS /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Part imore Examiner 7. Age (In yrs. last birthday) 87 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year 04-13-1919 Social Security Number 6. Sex XIXIM 2□F 9. Birthplace (State or Foreign **Funeral** Days Hours 413-16-7953 GEORGIA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 le marked other them "natural", or Items 23a or 28a-1 ehow eny injury or other treumatic event, the Margical Examinar mans the page. 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE LONG GREEN 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROAD 4607 LONG GREEN 21092 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? WXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married ★ Married 1 ☐ Yes XX No Specify: WHITE Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) AUTOMOBILE DEALERSHIP OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WEEKS JOHN POLLY RALSTRON ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4328 LONG GREEN ROAD, GLEN ARM, MARYLAND, 21057 CHERYL L. WINTER (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY M.G. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation XX Other (Specify) ENTOMBM T 09-18-2006 TIMONIUM, MARYLAND 21. Signature of Funeral Service Licensee 1050 YORK 22. Name and Address of Facility RUCK TOWSON FUNERAL HOME, INC. (R. G. RUTH) R. H. Kun TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOGENIC SHOCK Physician /Medical ACUTE MYOCARDIAL INFARCTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit CORONARY ARTERY DISEASE Due to (or as a consequence of) ettending physicien for use as the buria RESPIRATORY FAILURE Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant al time of death 5 Other (specify) signed by the e 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 🗌 Yes 2 12 10 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to complet not cause of death?
1 ☐ Yes No 24a. Was an page 2 s autopsy performe 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 A Inpatient 1 ☐ Yes 2 D No ဥ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27 Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31826 W UW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 RICHARD LINTHICUM M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 0 Registrar

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Baltimore, Maryland 21215-0036

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To the Hospital or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

			1 – For State Registrar	State of Ma	ryland /		artment o			and M		iene g. No.	006	2986	58
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	Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or L		f Death Baltim	ore	4c. Cour	nty of Death Baltin	nore	
	Funeral Director		5. Social Security Number 6. Security Number 217-14-5644  Usual Residence of Decedent	ex 7. Age Mg M 2 ☐ F	(in yrs. last 82	birthday) Yrs.	If Under 1 Months C	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Nov 11,	Year)	Cour	olace (State or For ortry) Virginia	reign
	Maryland a-f show iffed at	tor	10a. State 10b. County  Maryland Baltin	more	10c. City, T	own or Lo	cation	Balt	imore				1	10d. Inside City Lin	
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at anone.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:			Was Decedent If Yes, specify		panic Orig Mexican Specify:	in? (Spe , Puerto I	ocify Yes or No- Rican, etc.)		ace - Americ lack, White, cify:		
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	o the Ho	Medical	(Check only one)  2 Medical Examone)  29b. Signature and little of certifier	iner: On the basis of e and manner state	examination	and/or inv	estigation, in	my opin	nion, deat	h occurre	ed at the time, da	te and place	e, and due to	the cause(s)	
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			1 - For State Registrar	State of Maryl	and / Depa	artment of h rtificate of	lealth and Death	Mental Hy	giene 20 (	6 29869
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	Examir Funeral Director		4a. Facility Name (If not institution, given 6202 Candle Couts S. Social Security Number 6. S 577-40-3740	irt ex 7. Age (In)	yrs. last birthday) 75 Yrs.	Sykesvi If Under 1 Year Months Days	or Location of Deat  11e  If Under 24 Hrs  Hours Min.	8. Date of Birt	y, Year)	
			Usual Residence of Decedent  10a. State 10b. County		. City, Town or Lo	peation		Julie 9,	1931   Wa	10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural; or iteme 23s or 28a-f show any injury or other traumatic event, If a Madical Examinar must be notified at once.	I Director	Maryland Montgom  10e. Street and Number  3020 Bel Pre Road	#203	Sil	lver Spri	.ng 906		10g. Citizen of Wha	
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altimore,	it. Pages 1 intment of H intant: If ite njury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  21. Signatur of Funeral Service Licen	Removal from State	vational	natory or other place ington Cemetery	7 !12,	2006	20c. Location - City  Arlington	. Virginia
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	me 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		igin? (Specify Y		14. Ra	ce - Ameri	can Indian,	
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	res that signed b	by Pt	Part II. Other significant condition	s contributing to dear	th but not resulting	in the u	nderlying cause give	en in Part I	ı. 2	3e. Did tob	acco use co	ntribute to	the cause of o	death?
ğ	w require been sig should b	edt								1 ☐ Ye	s 2□No	3 ☐ Pro	bably 4	Únknown
င္ပ	e law re has be je 2 sho	Completed							2	4a. Was an		. Were aut	opsy findings empletion of a	available
<u> </u>	The page	Sol							1	perform	No No	death?	2□ No	
ij	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	00	e of Death (Che					
o	Phys this ral dir	2	1 Yes 2/ No 27. Manner of Leath	28a. Date of	atient 2 ER/O	utpatie		4 🗀 IN	ursing Home		nce 6 ⊡O winjuryocc≀		fy)	
Division of Vital Records,	ding f th: : After s funer	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month,	Day Yeer)	Injury	Worl	k? Yes 2 □			,,			
N	Atter	ifica	3 ☐ Suicide 6 ☐ Could no determin	ad 286. Place of	Injury - At home, t	arm, st	reet, factory, office			ocation (Str		nber or Rur	al Route Num	ıber,
	tal or rs afte et Dir ed in	Cert	4 Tionneldo	Daliding	, etc. (Specify)					nly or rown,	, 5(4(6)			
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the base and manne	is of examination a	ge, deat .nd/or in	h occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, and do	ue to the ca the time, da	use(s) and n ite and place	nanner as s , and due t	stated. to the causa(s	s)
<b>\</b>	withi To t	Σ	29b. Signature and offle of certifier	111			29c. License				d. Date sign			
	, ,		Mary W	DVL	1000		6H	415			09/17	120	06	
	24,		30. Name and address of person w	- ~ 1				rizzo	Do offered	110	Max-1.	and 2	0.850	
(3)	Sta	te.	31. Date filed (Month, Day, Year)	32. 100	pistrar's Signature	cal	Center D	TIVE	ROCKVI	тте,	rial y L	and Z	0000	
	Regist		SEP 2 0	2006	pistrar's Signature		male							
-		004				1					1.5	10		

			For State Registrer	State o	f Maryl	and / Dep <i>Ce</i>	artment o	f Healt of Dea	th and Nath	lental Hy	/giene Reg. No. 2	106	29871
	Physici	an	1. Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	Day	Year	3. Time of Death
	/Medio	cal	Barbara Joann 4a. Fecility Name (If not institution				4b. City, Tow	m or locat	tion of Death	Septem	ber 16,	2006 y of Death	12:58 A <sup>M</sup>
	Examir	ner	4238 Baylis (		1110017		Belca		don or Dead		Harfo		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2√2 F	7. Age (In	yrs. last birthday	If Under 1 Ye		nder 24 Hrs. urs Min.	8. Date of Bi (Month, D	irth		lace (State or Foreign try) Yland
	Director	ļ	212-46-4745 Usual Residence of Decedent	1 L M 2 X P	6	3Yrs.				Dec. 2	9, 1942	Mary	yland
	yland how		10a. State 10b. Count	у	10c	. City, Town or L	ocation					1/	0d. Inside City Limits
	the Marylan 28a-f show	Director	Maryland Harfo	ord		Belcan	jb di						1 ☐ Yes 2 ☐ No
(	6 after death with the Maryia or Itams 23a or 28a-f shor	Dire	10e. Street and Number				10f. Zip Coo				10g. Citizen of	What Coun	itry?
Z Z	death w ms 23a	Funerai	4238 Baylis Co	12. Was Dec		in U.S. 13.	Was Decedent If Yes, specify (		c Origin? (Sp	ecify Yes or N	USA o- 14. Ra	ce - Americ	
's n	after dez or Itams	Fur	1 Never Married 2 Ma	If Yes Gi	2 <b>N</b> o		If Yes, specify (		xican, Puerto <i>ecify</i> :	Rican, etc.)	Bla Specii	ick, White, e	etc.
) ne brenn	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23e or 28e-f show ant, the Morical Expendied at	ed by	3 Widowed 4 Divorce	d Year or D	ates:	164 Dags	edent's Usual Oc				16b. Kind of B	Whit	
מ י	215-	Be Completed		est grade completed)	1.4or 5.1	(Giv life.	kind of work do DO NOT use re	one during atired)	most of work	ing	TOD, KING OF E	usiness/inc	dustry
-1	d 2121 filed within Hygiene. wher then	Com	12			Recep	tionist				Hospit		
٠ ک	and 2	Be	17. Father's Name (First, Middle								e, Maiden Sumar	ne)	
) .	ire, Maryland 21215-003 s 1 and 2 should be filed within 72 hours f Health and Mental Hygiene, item 27 is marked other than "natural", other traumatic event, the Marical Ex-	Ç	Harry William I			19b. Mail	ing Address (Sti			ISY MCM	ullan ber, City or Town	. State. Zip	Code)
	md 2 satth ar alth ar 27 is		William A. Wine		Husbai	1					Maryland		
R	Baltimore, M permit. Pages 1 and 2 Department of Health a Important: If item 27 i any injury or other tre		20a. Method of Disposition 1 D Burial 2 Scremation	3 DRemoval from	State 20	b. Place of Disp				Date	20c. Location		
3	Limo Pag tment tent: I		`4 ☐ Donation 5 ☐ Other (	Specify)		Hilltop	Service	Corr	9-19	9-06	Towson,	, Mary	yland
Berbera	Baltimor permit. Pages Department of I Important: If its any injury or o		21. Signature of Puneral/Service	Licensee	_	2	2. Name and Ac McComas	dress of F Fune	eral Ho	ome, P.	Α.	3548	nd 21009
64	COLENA I		23a. Part1. Enter the disease,	or complication that	caused the	death. Do not er	131 / CO	dying, suc	ITY RO. h as cardiac	or respiratory a	gaon , Ma arrest,	ıryıar	Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition			STATI	CB	RE	AST	CAN	SCER	2 3	Onset and Death
	/Medical Examiner		resulting in death)	a		nsequence of):							37217
	LAGITITIE	F	Sequentially list conditions,	b	(or as a cor	sequence of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	(0, 40 2 00.								
,	60, be executed bician and burial-transit		resulting in death) Last	Due to	(or as a cor	nsequence of):							
	8760 icate be e physician s the buris	Physician/Medical		d	-								
•	BOX 68 eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pr	egnancy					23d Da	ate of delive	in.
1	Geath cert death cert e attending d for use a	iciar	in the past 12 months?	4⊟Pregi	oirth 2 🗍 nant at time		□Ectopic pregn: □ Other ( <i>specif</i> )						Day Year
(	hat the death	Phys	9 Unknown	9□ Unkn			-			1	-		
	DIVISION of VITAL RECONDS, P.O. BOX 68760, or Attanding Physician: The law requires that the death certificate be executed tirer death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	by	Part II. Other significant condit	tions contributing to d	eath but no	t resulting in the	underlying cause	e given in F	Part I.		tobacco use con Yes 2 ☐ No		ne cause of death? ably 4 Unknown
	aw requast been 2 should	Completed								24a. Was	s an 24b.	Were autor	psy findings available
!	The lav	mo								auto perf	ormed?	death?	npletion of cause of 2 No
;	Vital F iician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?					-	Place of Deat	h (Check only			
;	Sion of Vita tending Physician: leath. tor: After this certific the funeral director,	. To	1 Yes 2 No			2 ER/Outpatie			Nursing Ho		idence 6 Ott		1)
	Ion nding th. : After e funer	ation	1 Natural 5 Pend	ing (Mon tigation	of Injury th, Day Yea	ir) Injury		Injury at Work? 1 ☐ Yes	2 🗆 No				
	Division of Vital Records, I or Attending Physician: The law requires t after death. Director: After this certificate has been signe tin by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Could	mined 288. Place	of Injury ing, etc. (Sp	At home, farm, s	treet, factory, off	fice			(Street and Numi	per or Rura	l Route Number,
(	Hospital of the state of the st		29a, Certifier	ing Physician: To the	hest of my	knowledge dea	th occurred at th	se time dat	te and place	and due to the	cause/s) and m	annor ac et	atod
	Division  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A  completely filled in by the fu	edicai	(Check only 2 Medice one)	I Exeminer: On the b	asis of examiner stated.	mination and/or i	nvestigation, in r	ny opinion,	, death occur	red at the time.	, date and place,	and due to	the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certif	o Vl	212	MI	29c. Lic	cense num	ber	4	29d. Date signe	/	/
			30. Name and address of perso	n who completed cau	se of or th	tem 23a) (Type	Print) An+1	hony/	/ ( ¬	70 10°	753 Fall	//8/	
	5		John	ro Ho	pkin	is Co	ric	יי	'eti'		thervill		
	Sta Regista		31. Date filed (Month, Day, Yea	400	egistrar's S	Signature	and p						

DHMH 17 Rev 1/2001

ysician	Decedent's Name (First, Middle, CEDTDUDE	Last)		1101 500	ONI	2. Date of Death Month	Day	Year 3. T	ime of Death
Medical	GERTRUDE			WOLFS		Sapt	16 -	Z006 C	105 PM
iner	4a. Facility Name (If not institution, g	1 1 - 5	1	b. City, Town, or	r Location of Death	1-1.	4c. County	of Death	
		Sex 7. Age (In v.	eltmozi	f Under 1 Year	If Under 24 Hrs.	8. Date of Birth		N/	Α
ral tor	212-22-4464			Months Days	Hours Min.	02/07/19	327	Country)	State or Foreign
<i>)</i> (	Usual Residence of Decedent				1	02/07/13	/_/		110
	10a. State 10b. County	10c.	City, Town or Loca	tion				10d. In	side City Limits
ģ	MD	N/A	BALTIMOR	Ε				11	JYes 2∏No
al Direc	10e. Street and Number 6317 PARK HEIGHT	S AVENUE #407		10f. Zip Code 21215		10	-	What Country?	
Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Λ Year or Dates:		s Decedent of Hes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		e - American Inc ck, White, etc. WHITE	
eted	15. Decedent's (Specify only highest of	Education grade completed)	16a. Deceder	it's Usual Occupa	ation during most of workin	1	6b. Kind of Bu	usiness/Industry	
Idu	Elementary/Secondary (0-12)	College (1-4or 5+)			3)				
ပိ	12	- 43	HOM	EMAKER				HOME	
To Be Comp	17. Father's Name (First, Middle, La LOUIS	St/	KRAM	DE	18. Mother's Name	(First, Middle, M	aiden Sumam		ED
2		(Time Diet)			ANITA		-	FRI	
	19a. Informant's Name/Relationship LEONARD WOLFSON	/ HUSBAND	6317 P	ARK HEIG	AND AVENU	IE #407 -	- BALTI	MORE, M	D 21215
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	□Removal from State	i. Place of Dispositi cometery, cremat HIZUK AMU		1		ALTIMO	RE, MD	ate
	21. Signature of Funeral Service Lic		22. N	ame and Addres	ss of Facility SO	L LEVINS	SON & E	BROS., I	NC.
					STERSTOWN	ROAD - F	IKESVI		
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused the de ty one cause on each line.	eath. Do not enter t	he mode of dyin	g, such as cardiac or	respiratory arres	st,	Inter	oximate val Between
	Immediate Cause (Final disease or condition		COPD					Onse	t and Death
	resulting in death)	Due to (or as a cons	equence of):						7
	Sequentially list conditions.	b							
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):						
Examiner	Cause, Enter Unide lying Cause (Disease or injury that initiated events resulting in death) Last	c.							
cal E		Due to (or as a cons	equence or);						
		d.							
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3 Ed	topic pregnancy ther (specify)			23d. Dat Mor	e of delivery nth Day	Year
	Part II. Other significant conditions	contributing to death but not r	esulting in the unde	rlying cause ove	en in Part I	23e. Did toba	cco use contr	ribute to the caus	se of death?
d b		3 10 2220 200 1100 1	aa.	yourse give	mr swift to			3 Probably	4 □Unknown
ete									
Completed						24a. Was an autopsy performe	24b. V	Were autopsy fin prior to completic death?	dings available in of cause of
								Yes 2 N	0
Be	25. Was case referred to medical examiner?	Hospital:		. Other	26. Place of Death	Check only one			
2	1 Yes No	1 U Inpatient	-	3□ DOA Othe	4   Nursing Hom				
5	1 Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	<b>c</b> ?	8d. Describe how	injury occurr	ed	
=	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not	be Ose Bless of Leises At	<u> </u>		Yes 2 No	26.1			
20	4 Homicide determine	28e. Place of Injury - At building, etc. (Spe	cify)	factory, office	2	8f. Location (Stre City or Town,	et and Numbe State)	er or Rural Route	o Number,
ertifica		Physician: To the best of my k	nowledge death or	curred at the tim	and place as	nd due to the saw	22(2)		
il Certification;	29a. Certifier 1 Certifying I	Try distant. To the bost of the	nation and/or inves	tigation, in my op	pinion, death occurre	d at the time, dat	se(s) and ma a and place, a	nner as stated. and due to the ca	luse(s)
	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	eminer: On the basis of exami and manner stated.							
	Check only 2 Medical Ex	and manner stated.		29c. License	e number	290	<ol> <li>Date signed</li> </ol>	(Month, Day, Y	ear)
	one) 2 Medical Ex	and manner stated.		29c. License	number		-		
	29b. Signature and title of certifier		an (22) (7 5 5	B50	9 number 23/65 Z		-		
Medical Certifica	one) 2 Medical Ex		em 23a) (Type, Prii	B50	931657		-		
	29b. Signature and title of certifier		i-th	B50	a. Hos		-	Bor 16, Bult	

06-06920 QuWarren Wilson

# Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

, u v	varion vinoc		1- For State Registrar	Cer	tificate of		tarriygi	Reg.	No. 2	006	298
Vie	Physicia dical Exami	:111/	1. Decedent's Name (First, Middle,La	ren Wilson	n			Date of Death Month D September	ay Year 13, 2006		of Death 11 hrs
-			4a. Facility Name (if not institution, gir 231 North Kenwood Aven	ve street and number)	41	Baltimore City		·	4c. County of I	Death N/A	
3.8	Funeral Director		5 Social Security Number 6. S	ex 7 Age (In yrs. Ia	ast birthday)  33 Yrs.	If Under 1 Year If Under Months Days Hours	er 24Hrs 8 s Min.	Date of Birth(	MM/DD/YYYY)	9. Birthplace ( Foreign <b>A</b> Country)	State or W Jevsey
	Maryland 28a-f show any d at once.	or	Usual Residence of Decedent  10a State 10b. County  Maryland N	A 10c City,	Town or Locatio	Battimore	,				side City Limits Yes 2 No
	with the Maryland ms 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 231 No Kenw	ood Ave.		10f. Zip Code		10g.	Citizen of What	Country? USA	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sh af Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorce 15. Decedent's Education (Specify of	1 Yes 2 No If Yes, Give Year or Dates:	If Yes	Decedent of Hispanic Oris, specify Cuban, Mexicar  Yes 2 No specify.  Busual Occupation (Give	, Puerto Rica	an, etc.)	White, e	Black	an, 8lack,
	5-0036 led within 72 hour lygiene other than "natu	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	st of working life. DO NOT Disabled	use retired)		6b. Kind of Busir	A	
	21: De fill Sted Hed	Be Co	17 Father's Name (First, Middle, Las Lovenzo Rog.					st, Middle, Mai WilSon			
		To		mother	19b. Mailing / 2569	Edmondson		Val	ir City or Town,	State, Zip Coo Mary	ie) 21223 and 2
	more,  Aages   an ent of Hea nt: If iten		20a Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Specify  21 Signature of Funeral Service Lice	Removal from State	rematory or other	on (Name of cemetery, r place)  Cen Try  me and Address o Facilit	9/20	Local 2	Landsdu	ty or Town, S	la yland
	Physician	-	23a. Part I. Enter the Isease, or comfailure. List only one cause on e	Parker plications that caused the death.	351	2 Frederics	-Are	spiratory arrest	twork, A shock, or Heart		oximate Interval
	/Medical Examiner	3	Immediate Cause (Final disease or condition resulting in death)	Contact gunshot		head					Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of							
	760, icate be executed physician and the burial - transit		events resulting in death) Last		,,.						
	760, icate be ex physician the burial	Medical	X UNPENDED  IF FEMALE:	AMENDED item#23a,		perME,g860, 10	/6/06 T	Т	23d Date of de	elivery	
	Box 687  death certifice the attending p	sician/	<ul><li>23b. Was decedent pregnant in the past 12 months?</li><li>1 Yes 2 No 9 Unknow</li></ul>	Live birth     Pregnant at time of dealers	2 Feta	I death 3 Ectopi er (Specify)	c pregnancy		Month	Day	Year
	, P.O. B ires that the de signed by the be detached	d by Phy	Part II. Other significant conditions	contributing to death but not re	esulting in the un	derlying cause given in P	art I		cco use contribu		
	Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death for the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Completed			<u>-</u>		— 1	24a. Was an autopsy performe	prid ed? dea	ere autopsy fine or to completio ath? Yes	dings available on of cause of
	ital Recipions The scenificate rector, page	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	26 Place of Death 3 DOA Other	(Check only Nursing Ho		sidence 6	Other Seens	
	n of V ding Phys After this funeral di	n: To	1 Yes 2 No 27. Manner of Death	28a Date of Injury (Month, Day,Year)	28b. Time of Inj				v injury occurred		
	ivision  I or Attendi after death  Birector: /	catio	1 Natural 5 Pending 2 Accident Investiga	Fnd 9/13/2006	Fnd 5:57	- 1			shot self		
	Division ospital or chours after uneral Direction by filled in by	Certification:	3 XX Suicide 6 Could no determine		ome, rarm, street	Tactory, office building, e	Ba	or Town, State 1timore,	eet and Number of 231 N.	Kenwood	Ave.
	To the Hosp within 24 hd To the Fine completely I	Medical C		cian: To the best of my knowledger: On the basis of examination are and manner stated			ace, and due	to the cause(s	s) and manner as	s started.	
	F 3 F 5	ğ	29b. Signature and title of certifier			29c License number			9d. Date signed		Year)
			30. Name and address of person who	completed cause of death (Item	23a)	O.C.M.E.			September 1	4, 2006	_
		1	Ana Rubio MD. Assista	ant Medical Examiner	111 Penn St	reet, Baltimore, MD	21201				
	Si Regis	tate trar	31. Date filed (Month, Day, Year)	Registrar's Signatu	Local L	ر					

			1 - For State Registrar	State of M	•	epartment of l Certificate of			giene Reg. No. 20	06 2987
	Physici /Medic		Decedent's Name (First, Middle, La	Kathleen	Mary Wes	tphal		2. Date of Dea Month Septe		year 3. Time of Death 2006 2:30 M
	Examir			N. Chatham	Rd; Apt. A			licott CIty	4c. County of	Howard
	Funeral Director		,	Sex 7. A	ige (In yrs. last birth	Months Days				Birthplace (State or Foreign Country)  Pennsylvania
	B Maryland	ctor	10a. State 10b. County	loward	10c. City, Town		Ellicott City			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	ai Director	10e. Street and Number 3343 N. Chatham Roa	ad; Apt. A		10f. Zip Code	21042		10g. Citizen of Wh	nat Country? U.S.A.
936	hours after death with the Maryland tural; or Iteme 23e or 28e-1 ehow al Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	s? ] <b>\</b> \0	13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 ☐ KNo	oan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- American Indian, White, etc. White
9500-61212	be tiled within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or iteme 23a or 28a-1 ehow event, the Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr.			ecedent's Usual Occu Give kind of work done ife. DO NOT use retire Shipp	during most of w		16b. Kind of Busi	iness/Industry tationary company
Maryland 2	Mer ark	To Be Co	17. Father's Name (First, Middle, Last Walter	F. Westphal			18. Mother's Na	ame <i>(First, Middl</i> e, Ma	rgaret Mahe	er
_	d 2 s h ar 7 is 7 is		19a. Informant's Name/Relationship ( Ms. Barbara Holtz		ter		lighters Drive	Rural Route Numbe Ellicott City,	-	
altimore,	Pages nent of ant: if it ury or o		20a. Method of Disposition  1 ☐ Burial 2 ☐ Gremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		9	Disposition (Name of crematory or other plants of crematory or other plants of the cremated by		Date 09/18/2006		ity or Town, State altimore, MD
Ball	permit. Departr Importu any Inj		21. Signature of Fameral S Arice Lice	nsee	M00535	22. Name and Addre Slack 3871	Funeral Hor	ne, P.A. ia Pike Ellicot	t City. MD.2:	1043
2	Physician /Medical Examiner		23a. Paft1. Enter the disease, or con shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a	ed the death. Do no line.  DROUAGE s a consequence of	LY ARTO		ac or respiratory and		Approximate Interval Between Onset and Death
8/6U, <	icate be executed physicien and s the burial-transit	icai Examiner	Sequentiary list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of					
O. Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ◯ No 9 ☐ Unknown		e of pregnancy 2  Fetal death at time of death	3 ☐Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date Month	
, J	w requires that to been signed by should be detailed	ted by Ph	Part II. Other significant conditions	STRUCT1			ven in Part I.  DISEASE	.		ute to the cause of death?
Vital Records		e Completed	25. Was case relerred to medical				00 81		med de: 2 No 1	ere autopsy lindings available or to completion of cause of ath? ] Yes 2 \( \text{No} \)
_	> .∞ ¬	ToB	examiner?  1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending 2   Accident investigatio	Hospital: 1 Inpat	jury 28b. Tin	ne of 28c. Injury	ner: 4 Nursing	Home 5 Resid		
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of I	njury - At home, larmetc. (Specify)	n, street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	he Hospi in 24 hour he Funer pletely fill	Medical	(Check only 2 Medical Examone)	hysician: To the bes miner: On the basis and manner s	of examination and/	death occurred at the to or investigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time, o	ause(s) and mann late and place, an	ner as stated. d due to the cause(s)
Ħ	with To Com	2	29b. Signature an interest entitler	Mau	Men Mi	29c. Licen	se number D2990			Month, Day, Year) BRL 18, 2006
	φ Sta	ite	30. Name and address of person who Maurer, Scott MD 246 31. Date filed (Month, Day, Year)	35 Rt. 97 Gler	trar's Signature	738				
	Registr		SEP 2.02	417	and the	docates				

			1 = For State Registrar	State of M	1arylan	-	rtment o			, ,	jiene	nn <i>c</i>	20	075
	Physici	an	1. Decedent's Name (First, Middle, Li	•						2. Date of Dea Month	th Day	Vear	3. Time of t	Death
200	/Media	al	Lillian K. Ziegl  4a. Facility Name (If not institution, gi		-1		AL CIL To		(5)	Septem			1512	М
	Examir	er	Holy Cross Hospi		')			wn, or Location Llver S			4c. Coun	ity of Death Mon	tgomer	*17
	Funeral	-	5. Social Security Number 6.	Sex 7. A	ige (In yrs. I	ast birthday)	If Under 1	Year If Un		8. Date of Birth (Month, Day	1,, ,		ace (State or	-
	Director		219-18-1784	1 □ M 2 🖾 F	83	Yrs.	Months [	Days Hour	s Min.	Month, Day November	23, 192		$\frac{y}{y}$	
	pue *		Usual Residence of Decedent  10a. State 10b. County		10c Cib	/. Town or Lo	cation						od. Inside City	ı l i=it=
	f eho	ō	Maryland Montgo	merv	,	Olne						1	1 ☐ Yes	•
	1 the	rect	10e. Street and Number				10f. Zip Co	ode		1	0g. Citizen of	What Coun	try?	
	th with	aiD	17812 Princess A	nne Drive			20	0832			Uni	ted St	ates	
	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28e-f ehow the Madical Exeminer must be publied at	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.		Vas Deceden Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Spe	cify Yes or No-		ace - America		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give		Į	☐Yes 2∑				Spec	14		
21215-0036	ture!	ed b	15. Decedent's E	Year or Dates:	:	16a Deced	ent's Usual C	Occupation			16b. Kind of I	WII	ite	_
212	hin 72	Completed	(Specify only highest gr Elementary/Secondary (0-12)		54)	(Give	kind of work o	done during n	ost of workir	ng	TOO. TAING OF	203111033/1110	ustry	
21	giene giene	Com	Eldinomaly/obcorridary (0-12)	5+	3+)	Ph	ysicia	ın			Me	edicin	e	
nd	tal Hy dath	Be	17. Father's Name (First, Middle, Las William Otto Edw	•						(First, Middle, I		me)		
Maryland	ould d Mer narke	To			<u>.</u>	1.01.14.11				F. Bart				
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  In the Maryland of Hygiene is a state of the than "naturel", or items 23a or 28e-1 show eny injury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relationship Carol Ziegler /							<i>Route Number</i> ve, Olne				
Baltimore,	s f ar f Hea item		20a. Method of Disposition		0.00	ace of Dispos	ition (Name	of	D	ate	20c. Location			
Ë	Page nent c int: ff		1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		9	nt Oli			Septe	mber 2006 F	lanover	. Pen	nsylva:	nia
alt	permit. Departr Imports eny inju		21. Signature of Funeral Service Lice	nsee /		22 R.O	Name and A	Address of Fa	cility R88	ert A. I West Mo	umphre	ey Fun	eral H	ome/
<u> </u>	207 2 9		Per.		M01	Ro	ckvill	e, Mar	yLand	20850		zry Av	ende	
			23a. Part1. Enter the disease, or con shock, or heert failure. List only	plications that cause one cause on each	ed the death line.	. Do not ente	er the mode o	f dying, such	as cardiac oi	r respiratory arri	est,		Approximate Interval Betwo Onset and De	
E	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Sepsi										
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	71)	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			10					_		-
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8760,	be exected a	E	resulting in death) cast	Due to (or as	s a consequ	ience of):						-		
387	The law requires that the death certificate be executed the best been signed by the ettending physician and page 2 should be detached for use as the burial-transit	dical		_ d						-				
š	eath certific ettending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d D	ate of deliver		
Ď.	death e ette ed for	icia	in the past 12 months?	1☐Live birth 4☐Pregnant a			Ectopic pregr Other (specia						Day Ye	ar
P.O. Box	that the de ed by the e detached	hys	9 ☐ Unknown	9□ Unknown						1				
ŝ,	res tha signed be de		Part II. Other significent conditions	contributing to death t	but not resu	Iting in the un	derlying caus	e given in Pa	rt I.		acco use cor			
Records,	w require been sig should b	Completed								1 L Ye	s 2 No	3 Proba	.bly 4 ⊠Un	iknown
ec ec	hest hest	d L								24a. Was ar autops perform	Y	Were autop prior to com death?	sy findings av	/ailable use of
Vital	n: Th ficete or, pag		OF Monocon referred to medical	T						1 ☐ Yes 2	⊠ No	1 Yes 2	2 □ No	
<u>=</u>	hysician: The Iz	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ient 2 🗆 F	R/Outpatient	3□ DOA	04		(Check only only only only only only only only	*	h (C t		
ַס	ig Phy ter thii neral c		27. Manner of Death	28a. Date of Inju		28b. Time of		Injury at Work?		8d. Describe ho				
201	tending lasth. tor: After the funer	atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	ay roar,	Injury	М	1 ☐ Yes 2	□No					
Division of	i or Attendatter deatt Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ijury - At hor tc. (Specify,	me, farm, stre	et, factory, of	fice	2	8f. Location (Str. City or Town	eet and Num , State)	ber or Rural	Route Numbe	ər,
	Hospital (14 hours al Funerel Dite) filled i		29a. Certifier 1⊠ Certifying Pl	hugieien. Te she head		de de la dela de								
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Example)	hysicien: To the best miner: On the basis of and manner st	of examinati	on and/or inv	estigation, in	my opinion, d	and place, ai leath occurre	nd due to the ca d at the time, da	use(s) and mate and place,	anner as sta , and due to	ted. the cause(s)	
	vithin 2 To the I complet	Me	29b. Signature and title of certifier	1			29c. Li	cense numbe	er	29	9d. Date signe			
3	1		- Been	1			D6	4024		6	9/14	120	06	
	15		30. Name and address deperson who Janna Dachtchini:					ad Ci	13702 0	Shrine	Martila	nd 20	910	
	-Ct-		31. Date filed (Month, Day, Year)		rar's Signati		Tell VO	au, DI	TVEL S	brrng,	maryra	4U	710	
	Sta Registr		Programme and the second	UZ. Magisti			) a							

ORIGINAL

		1	1 - For Amend item#5, pe	State of Mary erFH,G859,9/22/0	$^{ m land}$ / Dep $^{ m lond}$ / C $\epsilon$	artment of Health and I ertificate of Death	Mental Hygid Reg	ene 2 () () ( j. No.	5 29876
	Physici	an	1. Decedent's Name (First, Middle, La.		Alston		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Letha. 4a. Facility Name (If not institution, giv.		HISTON	4b. City, Town, or Location of Deatl	Sept	14 2000 4c. County of Deat	2
	Examin	er	Mercy Medical	Center		Boltmore		n/	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day,	(ear) 9. Birt	thplace (State or Foreign
	Director		214- <del>34-</del> 6025  Usual Residence of Decedent	LM ZAIF	65 Yrs.		9/22/4	) Ma	ryland
	/land		10a. State 10b. County	100	. City, Town or L	ocation			10d. Inside City Limits
	a-fsh	ctor	MD n/a		Balti	more			1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Co	ountry?
	s 23e	erai	408 Mt. Holly	Street 12. Was Decedent Ever	in II S 13	21229 Was Decedent of Hispanic Origin? (S	pacify Yas or No-	USA 14. Race - Ame	ancan Indian
21215-0036	s within 72 hours after deeth with the Maryland Jiene. I than "natural", or Itame 23a or 28e-f show The Medical Ezamirat must be modified at	by Funeral	1 Never Married 2 Narried 3 Widowed 4 Divorced	Armed Forces?  1  Yes XXNo If Yes, Give Year or Dates:	13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White	
5-0	72 ho	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deci (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	king	6b. Kind of Business	•
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2+			]	Federal	Gov't
	T thy	0	17. Father's Name (First, Middle, Last,		sec	retary 18. Mother's Nar	ne (First, Middle, Ma	aiden Sumame)	
/lan		To B	William D. Meg	gett		Hattie	Meggett		
Maryland	2 should and Men Is marke aumatic	į 4	19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ing Address (Street and Number or Ro	ıral Route Number,	City or Town, State, .	Zip Code)
	es 1 and 2 should of Health and Mei item 27 is mark r other traumatio		20a. Method of Disposition Engl	Jr./Husban	405 0b. Place of Disc	Mt. Helly Stre	et, Eal	C Location - City or	21229 Town State
Baltimore,	Pages nent of h int: If its iny or o'		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 ☒ Other (Specif						
altin	그 된 본 중 .		21. Signature of Fundad Service Con		woodia	vn Cemetery $9/2$	lie F/H	P.A. of	Balto. Co.
ä	Depa Impo any in		Valle.		92	200 Liberty Rd.	, Randal	llstown,	MD 21133
1			1/	plications that caused the one cause on each line.	death. Do not ei	nter the mode of dying, such as cardia	or respiratory arres	st,	Approximate Interval Between Onset and Death
31.00	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sepsi	5				
	Examiner			Due to (or as a co	nsequence of):				
	7 -	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a co	ns wience of				
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co					
60,	icate be executed physicien and s the burial-transit	al E	,	. Due to (or as a co	nsaquanca or).				
68760,		edical		_ d					
P.O. Box	Physician: The law requires that the death certific this certificete has been signed by the attending piral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
	es that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
ords	w require been sig should b		Breast Con	cinoma Pul	morary	Embolism	1 ☐ Yes	2 <b>□</b> /No 3 □ P	robabły 4 Dunknown
al Records,	: The law r cete has be page 2 sh	Completed					24a Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
of Vital	sician: The certificete	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ☐ ER/Outpatie	100	ath (Check only one	ce 6 ☐Other (Spe	2016.1
		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time		28d. Describe hov		(City)
sion	E - 7 5	atio	1 Natural 5 Pending 2 Accident Investigation	n	ary inquiy	M 1 Yes 2 No			
Division	tai or Attend s after death el Diractor: , ed in by the i	Certification:	3 🗍 Suicide 6 🗎 Could not be 4 🗎 Homicide determined			treet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funerel Dirac completely filled in by	Medicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicat Example 1	hysician: To the best of m miner: On the basis of exa and manner stated.	y knowledge, dea mination and/or	ath occurred at the time, date and place nvestigation, in my opinion, death occu-	e, and due to the cau irred at the time, dat	use(s) and manner a ee and place, and du	s stated. e to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier			29c. License number		d. Date signed (Mon	
•	,		· GALLA	no		P19699		Sept 14	, 2006
	0			Hman MO	30/	St. Paul Place	Ba Himo	re MD	2/201
***	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SFP 2. 1. 2	32. Registrar's	Signature	Couli			

			1 - For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artmeni rtificate	t of He e of D	ealth ai Death	nd Me	ental Hyg	giene 1eg. No.	006	298	77
	Physici /Medi		Decedent's Name (First, Middle, Lisa	Last)		Ash	e				2. Date of Dea Month		006 Year	3. Time of D 4:05p	eath M
	Examir		4a. Facility Name (If not institution, Liberty Height	s Rehab	. Cente		Ва	ltim				4c. Co	unty of Death		
	Funeral Director		5. Social Security Number  212-88-1847  Usual Residence of Decedent	3. Sex 1	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	B. Date of Birth (Month, Day 26	Year) 64	Cou	place (State or I	Foreign
	e Maryland Sa-f show	ctor	10a. State 10b. County MD NA			City, Town or Lo								10d. Inside City	
	hours after death with the Maryland lursi', or iteme 23a or 28a-f show all Examinar must be notified at	by Funeral Director	10e. Street and Number  913 Pennsylva  11. Marital Status		re Apt		10f. Zip	2	1201	n? (Spec			U . S . A	•	
9800	nours after o ural, or iter LExaminar	d by Fun	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F	Forces? 2 <b>X</b> No Sive	1	fYes, spec 1⊡Yes 2			Puèrto R	ify Yes or No- ican, etc.)	Sp	Black, White,	etc. lack	
Maryland 21215-0036	within 72 ane. than "na	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	life.	dent's Usua kind of wor DO NOT us le Ma	rk done du se retired)	iring most o	of working	7	16b. Kind	of Business/In	<sup>dustry</sup> Unk	nowi
ryland	Mer Mer	To Be (	17. Father's Name (First, Middle, L	Sr.		don Marii			Joyce	e Ch	First, Middle, atmon	3			
	1 and 2 s Health ar em 27 is ther trau	1	James Ashe Jr.  20a. Method of Disposition	-Husbar	206.		Mori	time	r Av		Route Number Balto, te	Md	2121	5	
Baltimore,	permit. Pages Depertment of Important; If it any injury or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Li	city)	State Ki	ing Me	moria . Name and	al P	ark of Facility	1	March F	.H. W	lest	own, M	Id
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	nry one cause on	each line.	ath. Do not ent	er the mode	e of dying,	such as ca	ardiac or		est,		21215 Approximate Interval Betwee Onset and December 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
	Priysician /Medical Examiner		disease or condition resulting in death)  Sequentially list conditions,	Due to	o (or as a conso- cirline	quence of):	th v	imm	unoc	defi	rienny	synd	rome	570	r -
8760,d	cate be executed physicien and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse										
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregr birth 2 Fet gnant at time of nown	al death 3	Ectopic pre					23d.	Date of delive	ery Day Yea	ar
	w requires that been signed b should be deta	ρ	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying ca	ause giver	n in Part I.					ne cause of dea	
Division of Vital Records,		Completed								_	24a. Was a autops perform	ned?	prior to con death?	psy findings avan pletion of cause 2 No	ailable se of
Z Z	sicien: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		7.50.0					Check only on				_
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	To the Hospitel or A within 24 hours after To the Funerei Directorpletely filled in by	ledicai	(Check only 2 Medical E:	Physician: To the caminer: On the and ma	basis of examin nner stated.	owledge, death ation and/or inv	estigation,	in my opi	nion, death	place, an occurred	at the time, d	ate and pla	ce, and due to	the cause(s)	
)	Mith To	Σ	29b. Signature and title of certifier  W 22 - 0	Kiny	mb				1565			91	gned (Month,	•	
	3.		30. Name and address of person w	no completed car	use of death (Ite	m 23a) (Type,	Print)	u s	treet	_	Best	nare	mel	2/20/	
	Sta Registr		30. Name and address of person w  Mign - Dow Ki  31. Date filed (Month, Day, Year)  SEP 2 1 2	32.	Registrar's Sign	ature	after &							/_	

Physici	an	1 - State Registrar  1. Decedent's Name (First, Middle, Last Andrew	Winfie]	ld Ro	ttese		2. Date of Dear	Day Year	3. Time of Death
/Medic		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Deal		ber 15,200 4c. County of Dea	
Examin	er	Southern Maryland				inton	•••	Prince G	
Funeral		5. Social Security Number 6. Se		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth	o Pi	rthplace (State or Foreign
Director		323 74 0070	JW 5 -	73 Yrs.	Line Buys	1,0410	June 11	,1933 Ark	ansas
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Mary -feho	ţō	Maryland Prince Ge	orge's	Upper	Marlboro				1 ☐ Yes 2√€ No
h the	lrec	10e. Street and Number		1.1	10f. Zip Code		1	0g. Citizen of What C	ountry?
th wit	alD	8307 Grandhaven Av	enue		20	0772		U.S.	Α
within 72 hours after deeth with the Maryland ene. Then "naturel", or Itema 23a or 28a-f ehow he Madical Examinar must be notified at	Funeral Directo	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2♥ If Yes, Give A Year or Dates:	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 □ Yes 2 🛣 No		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
A 13-003 ithin 72 hours ite.	ed by	3 ☐ Widowed 4 ☐ Divorced		16a. Dece	dent's Usual Occupa			Specify: Wh	
Pi Pi Pi Pi Pi Pi Pi Pi Pi Pi Pi Pi Pi P	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or:	life.	kind of work done d DO NOT use retired;	luring most of wo	orking		•
A With	Con	12th	4		Director			Federal G	overnment
be filed hal Hyg od othe	Be	17. Father's Name (First, Middle, Last) Andrew W. Battes	e Sr				me (First, Middle, I 1e France	· ·	
Mal yialla Z d 2 should be filed v lth and Mental Hygie 27 is marked other t treumatic event, ib	ပ္	19a. Informant's Name/Relationship (T		19h Maili	ng Address (Street a			City or Town, State,	Zin Code)
ie, mai yic s 1 and 2 should f Health and Mer item 27 1s marke other treumatic		ANita Battese (Wi						Marlboro	
mit. Peges 1 ar partment of Hea partment of Hea portant: If item y injury or other ica.		20a. Method of Disposition		20b. Place of Dispo	esition (Name of matory or other place			20c. Location - City of	
Peges nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		Resurrec	tion Cemet	tery 20	006	Clinton,	Marvland
Daltimo		21. Signatury of Funeral Septic Licens	and ma					l Home, Ind	on, MD 20735
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	d the death. Do not entine.	er the mode of dying	g, such as cardia	c or respiratory arm	est,	Approximate Interval Between
Pnysician	Š.	Immediate Cause (Final disease or condition	a		ngarag	en he	Lim		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
LAdiffiller	e	Sequentially list conditions,	b. Due to for de	a consequence of):					3 days
uted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Surati	Aspi	ration 1	Pneumonia		7 1
be executed siclan and burial-transit	Еха	resulting in death) Last	Due to (or as	consequence of):	7				
the ate	dlcal		d		*****				
eath certific attending pl	/Mec	IF FEMALE:	23c. If yes, outcome	of programmy					
ath ath for u	clan/Me	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
. 0 0 0	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
ecords, F.O. law requires that the de es been signed by the 2 2 should be detached i	by P	Part II. Other significant conditions co	ntributing to death t	out not resulting in the u	nderlying cause give	in in Part I.	23e. Did tol	pacco use contribute t	to the cause of death?
v require	ted t	- Smiltinge	in Fa	eline			1 🗆 Ye	es 2⊡No 325]P	robably 4 Unknown
The law requires to the hes been signed as a should be consigned.	Completed	Chrome C	65 fret	nel Pont	may &	Doney	24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of
	Be Co	25. Was case referred to medical				26 Place of De	1 Yes a		s 2□No
ysicia ils cer direct	To B	evaminer?	Hospital: 1 Mnpati	ent 2 ☐ ER/Outpatier	nt 3 DOA Othe		The second second second	ence 6 □Other (Spe	ecify)
Ing ling After uner		27. Manner of Death 1 S Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time o Injury	f 28c. Injury Work	at ? /es 2 □No		ow injury occurred	
DIVISION OF	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Place of In	jury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Bural Route Number,
pital o		27a Conffier 1X Certifying Phy	reiniam. To the boat	of my knowledge, deat	le marine di ad din Sian	. data and illan	and the to the e	mandel and viscois a	
To the Hospital or Al within 24 hours effer of To the Funarel Direct completely filled in by	edlcal	(Check only 2 Medical Exam	iner: On the basis of	of examination and/or in	vestigation, in my op	inion, death occ	urred at the time, d	ate and place, and du	e to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier		4	29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
		/ Jimfin	me		1.	20827	4	9/15/26	2
11		30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type, Mr. AVC - #	Print)	n.	7. 11	nm	3 4 4 7 -
1 1 .									
\2 Sta	to	31. Date filed (Month, Day, Year) SEP 2 0 200	32. Regist	rar's Signature	18 01pg	DER //	BRIBORC	11100	20112

			1 - For State Registrar	State	of Mary		artment of I				iene <sub>eg. No.</sub> 2	006	29879
· v	P 1 196	S. dec	Decedent's Name (First, Middle	e, Last)	-					2. Date of Dea	h		3. Time of Death
	Physic /Medi		CHARLES H. BAS	CHART. JE	₹.					Month 09	Day 11.	2006	6:30 A M
	Exami		4a. Facility Name (If not institution				4b. City, Town,	or Location	of Death			unty of Death	0.30 A
450			501 E. 41ST St				BALTIM	ORE					
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday	) If Under 1 Year Months Days			8. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreign
<u>tu</u>	Director		218-22-9356	1 <b>∑</b> M 2□ F		81 Yrs.		110010		09/07/			MD
	bug *		Usual Residence of Decedent  10a, State 10b, County		10	c. City, Town or I	ocation						10d. Inside City Limits
	/anyli	5											1 XYes 2 □ No
	28a-	Director	MD 10e, Street and Number			BALTIMO	10f. Zip Code			1	On Citizen	of What Cou	ntn/2
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or Itams 23a or 28a-f show event, the Medical Examinar must be notified at			n				<b>.</b>		- "	-		y.
	ns 2	Funeral	501 E. 41 ST ST		cedent Ever	r in U.S. 13	21218 Was Decedent of I		rigin? (Spec	ify Yes or No-	USA 14.	Race - Ameri	can Indian.
0	riter	Fun	1 Never Married 2 Marr	Armed I	Forces?		Was Decedent of I If Yes, specify Cub			ican, etc.)		Black, White,	
215-0036	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, 0 Year or	Give		1 ☐ Yes 2 🙀 No	Specify	<i>/</i> :		Sp	ecify: WH]	TE
2	72 ho	Completed	15. Deceden (Specify only highes	's Education	<del>-</del> (1	16a. Dec	edent's Usual Occu e kind of work done	pation	et of working	2	16b. Kind	of Business/In	dustry
2	o o	nple	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use retire	ed)	St Of WORKING	9			
7	ygien ygien t, th	S	12TH			CU	STODIAN	η					BALTIMORE
מ	0 = 0 5	Be	17. Father's Name (First, Middle,	Last)					ner's Name (	(First, Middle, I	Aaiden Sui	mame)	
<u>×</u>	should by nd Menta marked imatic ev	ဥ	CHARLES H. BASI		₹.			UN					
Maryland	2 sh and is m		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mai	ing Address (Street	t and Numb	ber or Rural	Route Number	City or To	wn, State, Zip	Code)
_	s 1 and f Health itsm 27 other t		DOROTHY SADDLE	₹			1 E. 41SI	ST.				21218	
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from		Ob. Place of Disp cemetery, cri	ematory or other pla	ice)	Da	ite	20c. Locati 2901	on - City or To TAYLOR	own, State RAVE.
	permit. Pag Department Important: i any injury o		4 ☐ Donation 5 ☐ Other (S			MORELAN	D MEM. PA	RK	09/21	/2006	BALTI	MORE C	O., MD
g	Department of the partment of		21. Signature of Funeral Service	Licensee			2. Name and Addre	ess of Facil	WESL	EY CHAV	IS, J	JR. FNF	L. HM.
	40144		Music	ey M	an		2007-09	EAST	TERN A	VE., BA	LTIMO	DRE, ME	
A.			23a. Part1. Enter the disease, or shock, or heart failure. Light	only one cause on	each line.	death. Do not el	nter the mode of dyi	ng, such as	s cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Mel	asta	elie 59	Mamor	US.	cell	Can	eer		195 han
	/Medical Examiner		resulting in death)	Due to	o (or as a co	nsequence of): $ u$						1	one year
1	* * *	<u>_</u>	Sequentially list conditions,	b. — Due to	- /							L	The free c
_	ed isit	Jine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a co	insequence of):							
	be executed icien and burial-transit	Examin	that initiated events resulting in death) Last	c	o (or as a co	insequence of):		-					
8/60	cate be executed physicien and the burial-transit	a			,								
	physicate sthe l	edical		d									
×	requires that the death certifi: sen signed by the ettending f hould be detached for use as	/Me	IF FEMALE:	23c. If yes, o	utcome of p	regnancy					224	Date of delive	
X Q Q	eath etter	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live		Fetal death 3	□Ectopic pregnanc □ Other (specify)	y			230.	Month	Day Year
j	the d y the ched	ıysı	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk		0. 000							
J.	that led b deta		Part II. Other significant condition	ns contributing to	death but no	ot resulting in the	underlying cause giv	ven in Part	1.	23e. Did tob	acco use o	contribute to t	ne cause of death?
Sp	uires sigr Id be	d by								1 🗆 Ye	s 2 🗆 N	o 3 🗆 Prot	pably 4 Unknown
Hecord		ompleted								24a. Was a	2	th Were auto	nsy findings available
ů Ľ	The law cate has b page 2 s	E D								autops	ned?	death?	psy findings available mpletion of cause of
	(0	e C	25. Was case referred to medical					00 81		1	<b>X</b> (No	1 🗆 Yes	200No
5	Physicien: this certific ral director,	o B	examiner?	Hospital:	Inpatient	2 ER/Outpatie	ot all post of	nor:		Check only on		21. (2. )	
		<b>-</b>	27. Manner of Death	28a. Date	e of Injury	28b. Time				e 5 Reside			y)
Sion	th: Afte	tion	1 Natural 5 Pendin 2 Accident investig	9	inth, Day Ye	ar) Injury		rk? ]Yes 2.⊟			• •		
<u>  S</u>	Attending ir death. ector: After by the fune	fice	3 ☐ Suicide 6 ☐ Could r	ined 286. Plac	ce of Injury -	At home, farm, s	treet, factory, office		28	3f. Location (St	eet and No	umber or Rura	il Route Number,
<u>≥</u>	a afte	Certification:	4 Homicide	buil	ding, etc. (S	ipecity)				City or Town	, State)		
	To the Hospitel or Attendin within 24 hours after death. Fo the Funerel Director: Att completely filled in by the fun		29a. Certifier 1 Certifyin	g Physician: To th	ne best of m	y knowledge, dea	th occurred at the til	me, date a	nd place, an	nd due to the ca	use(s) and	manner as s	tated
	n 24 n 24 he Ft	edical	(Check only 2 Medical one)	Examiner: On the	basis of exa inner stated.	mination and/or i	nvestigation, in my o	opinion, dea	ath occurred	d at the time, da	ite and pla	ce, and due to	the cause(s)
	Somp State	ž	29b. Signature and title of centile		0.4.4.	na A	29c. Licens	se number	/1	25	d. Date	ned (Month,	Day, Year)
^	1		shieth	(my	julia	ælli	$\mathcal{D}$	2066	01	*	repli	well	19"2000
- 1			30. Name and address of perion	who gampleted car	use of death	(Item 23a)/(Type	Printy2 DIT	7n ~	1	Hal	10	102	9
0			30. Name and address of per in	Kave	er lo	IXIC.	12alli	INE	le -	109-	_	イとノ	/
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's	Signature							
18.5	Registr	'ar	SFP 2 1	2005		10 1	The state of						

ORIGINAL

Death

Year

No

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 2700 Broening Highway Berth #2, Dundalk, Md

September 20, 2006

29d. Date signed (Month, Day, Year)

Certification: Sep 19, 2006 1036 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be (Specify) Harbor determined Homicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbei nd address of person who completed cause of death (Item 23a Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

Pending

Yes 2 V No

O.C.M.E.

g859 9/21/06 KRH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20a-22 per F.H. State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registra Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NicolP Savannah 902 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Medical Center undel 4nne Arundel nnapolis If Undar 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Days Hours 1 ☐ M 2 🕏 F Yrs. aru Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s or 28s.1 - hour 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23a or 28a-f ahow Examiner must be notified at 1 Tes 2 Sto Arnold Director Maryland unde 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 0 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2☐NO 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) never worked worked never 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen Morgan Amy Fdward ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ingate Terrace Hale Thorpe, Md. 1ichael Morgan Uncle 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven 7/18/06 Glen Burnie, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir Slack F. H. 3871 Old Columbnia Pike Melody A. Bright (per DVR) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dai **Physician** /Medical Due to (or as a consequence of) Examiner eptococcus Sepsis 6 roup Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death jo Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) Yes 2 No be detached 9 Unknown 23e. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 1 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1□ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 000 2 1 Inpatient 2 ER/Outpatient 1 Yes 3□ DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier September 8,2006 47158 NeD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, ann-Yann Medica ar Kway 2001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 Registrar

DHMH 17 Rev 1/2001

SEP 2

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Agnes Bonnett September 15, 2006 | 03:25 p.<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore N/A 3728 Frankford Avenue Months Days Hours Min. April 27, 1904 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕶 F 212-34-8306 102 Yrs Director Marvland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at N/A Baltimore 1 XYes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3728 Frankford Avenue 21206 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3)(Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Own Home Homemaker 6 yrs. permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth any liquy or other treumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Urbanski Victoria Rybarczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Mary Cabrini Bonnett/Daughter 1525 Marriottsville Rd. Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cem. 09/19/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE TO THRIVE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and al-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien are the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖸 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Arterial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed peed Mitral Stenosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an hes page certificate 1 ☐ Yes 2 🎇 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ٩ 1 ☐ Yes 2 X No 3 DOA After this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature)and title of certifier D31230 September 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 301 St. Paul Street, Suite 310 Robert V. Zawodny, M D. Baltimore, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 1 2006

			1 - For State Registrar	State of M	laryland	l / Depa <i>Ce</i>	artment of F rtificate of	lealth a Death	and M		giene Reg. No.	2006	29883
	Physici /Medio		Decedent's Name (First, Middle, La Carolyn Rose Baker	st)						2. Date of De.	+ Day	13,200	3. Time of Death
	Examin		4a. Facility Name (If not institution, given	re street and number	USPI+	al	Ab City, Town, of	r Location o	ot Death	v ty	4c.	County of Death	h
I	Funeral Director		5. Social Seedrity Number 6. 9 109–40–1122	Gex I□M 2☐F 7. A	ge (in yrs. ia 59		If Under 1 Year Months Days	It Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 05/03/	h Y. Year) 1947	9. Birtl Co	hplace (State or Foreign untry) MD
	death with the Maryland me 23a or 28a-f ehow (must be notified at	ctor	Usual Residence of Decedent	1		Town or Lo	ocation Mason Court	t (Balt	imore	City)			10d. Inside City Limits  1  Yes 2  No
	3 with the	il Director	10e. Street and Number 353 S. South Mason Cou	ırt			10f. Zip Code	212	31		10g. Citiz	en of What Co	untry? USA
9500	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene tem. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examiner must be notified at	by Funeral I	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2 HYes, Give Year or Dates	? ] No	i	Was Decedent of Hit Yes, specify Cub. 1 ☐ Yes 2 1 No	lispanic Ori an, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: Bla	e, etc.
0-6171	within 72 ho ene. then "natur he Modical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ade completed) College (1-4or	5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during mosi d)	t of worki	ng		nd of Business/I	
/iand z	should be filed nd Mental Hygid marked other Imatic event, III	To Be Co	17. Father's Name (First, Middle, Last Harold Baker	4 yrs.		1	est Monitor	18. Mothe		(First, Middle, Alston	Balti Maiden	more City Sumame)	7
Mar	and 2 sho saith and I n 27 is me		19a. Informant's Name/Relationship Amanda Sanders / Da				ng Address (Street . Mason Cou				er, City or 21231	Town, State, Z	(ip Code)
more,	90 = 5		20a. Mathod of Disposition  1 Burial 2 Cremation 3 [ 4 Donation 5 Other (Speci		e cei	metery, crei	osition (Name of matory or other plan demetery		09/22	/2006		cation - City or	
pairil	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Lice		)	2:	2. Name and Addre	ss of Facilit	y Wy1	ie Funera	al Hom	timore, M ne, P.A. 1217	ND .
8/60,	death certificate be executed  Magnetical and burial-transit  death of or use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or con shock, or heart tailure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to for a Due to for a C. MORK	ad the death. line.  LEAT  s a conseque  s a conseque  LA  s a conseque  s a conseque	ence ot):  MSi ence of):  Obl.	1 , 0	Oli /M			rrest,		Approximate Interval Between Onset and Death
O. BOX 6	death certif e attending id for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal o	death 3	Ectopic pregnance Other (specify)	′			2	3d. Date of deli Month	very Day Year
Records, P.	The law requires that the site has been signed by the bage 2 should be detache	ted by Ph	Part II. Other significant conditions  Chronica 0137	contributing to death	Puln	ting in the u	inderlying cause give	en in Part I.			obacco us		the cause of death?
Vital Rec	The lay	e Completed	Diable fe 5 // E  por thy Ane // 25. Was case referred to medical	pia, Pul	nory	Jype	rtension	26 Blood	ny Door		osy rmed? 2 \( \text{No}	prior to death?	topsy findings available completion of cause of
2 2	hysicia this cert al direct	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpai		R/Outpatier	IL 30 DOX	er: 4 □ Nu	rsing Hor	ne 5 ☐ Resid	dence 6	☐Other (Spec	city)
Division	tending Ph death. tor: After th the funeral	Certification;	27. Manner of Death 1 Patural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ay Yeer)	28b. Time o Injury	Wor	yat rk? Yes 2 □ l	No	28d. Describe I			
Ž	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		4 Homicide determined	building,	etc. (Specify)		reet, factory, office			City or Tov	vn, State)		ral Route Number,
	he Hosp n 24 hou he Fune pletely fi	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medicat Exa	hysician: To the bes miner: On the basis and manners	ot examination	rledge, deat on and/or in	th occurred at the till evestigation, in my o	me, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
)	To the within 2 To the complete	Σ	29b. Signature and title of certifier	hddu	gan	$\wedge$	29c. Licens	955 1955	55		29d. Date	signed (Month)	n, Dey, Year)
	2		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print	nd 6	ren	eral	Ho	spita	Q
	Sta		31. Date filed (Month, Day, Year)	2006 32. Regis	trar's Signati	ire.	Carles				,	1	

	_	For State Registrar	Cei	artment of Health and rtificate of Death	Reg.	
Physicia /Medic	in J	1. Decedent's Name (First, Middle, Last THELMA P. BAND			2. Date of Death Month SEPTEMBE	Day Year (2:05 A M
Funeral Director	er	4a. Facility Name (If not institution, give ST. A GNES  5. Social Security Number 6. S  200-09-9597  Usual Residence of Decedent  10a. State 10b. County	HOSPITAL	4b. City, Town, or Location of Deal BALT, Mo & E  II Under 1 Year If Under 24 Hrs Months Days Hours Min.	, MD	
Maryla -fehov	ţō	MD N/A		DRE CITY		1 XYes 2 No
3a or 28a	Funeral Director	10e. Street and Number 3506 CALLOWAY	AVENUE	10f. Zip Code 21215	10g.	Citizen of What Country?
1715-0036 within 72 hours effer death with the Maryland ene. than "naturel", or items 23s or 28s-f show than "mayleal Exerciper mout be rediffed at	۾	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
CA B D P P	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12TH	College (1-4or 5+)  8 YEARS  (Give life.)  DE	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)  EAN OF EDUCATIO	on U	D. Kind of Business/Industry  IORGAN STATE  INIVERSITY
land lid be fi lental H ked ott	To Be	17. Father's Name (First, Middle, Last, HENRY J. PREY			me <i>(First, Middle, Maid</i> ERINE PER	
Maryland of 2 should be file tith and Mental Hy 27 is marked oth	-	19a. Informant's Name/Relationship ( ARTHUR DRAGER	Type, Print) 19b. Mailin ESQ. GUARDIAN 10 N	ng Address (Street and Number or R		•
altimore, mit. Pages 1 ar partment of Hea portant: if them: y injury or other		20a. Method of Disposition  1 Substitution 2 Cremation 3 4 Donation 5 Other (Specific	20b. Place of Dispo cemetery, crei	sition (Name of	Date 20c	ALTIMORE CO., MD
Balti permit. Departri Imports any inju		21. Signature of Theral Service Licer	CI I away 4	600 LIBERTY H	ETGHTS AV	ERAL HOME 21207 E, BALTIMORE, MD
Physician /Medical Examiner	. 1	23a. Party Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not entone cause on each line.  a. HEMOLYTIC  Due to (or as a consequence of):	er the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
68760, ficate be executed physician and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (cr as a consequence of).  C. Due to (or as a consequence of):  d.			
Geath certification of the use e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2.□ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ecords, P.O. law requires that the es been signed by th	ک		ontributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?
Record	Completed	DEMENTIA	· · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy performed 1 Yes 2	
Vita	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)	
Physer this seral dia	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time o	K 3 DOA 4 INdising	dome 5 Residence 28d. Describe how in	e 6 □Other (Specify) njury occurred
Division of Vital Records, To the Hospital or Attanding Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 5 Pending Investigatio 6 Could not be determined		M 1 Yes 2 No	28l. Location (Street City or Town, S.	t and Number or Rural Route Number, tate)
Hospita     24 hours     Funerel letely filled	edicai C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	l iysician: To the best of my knowledge, deat niner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	okomer, MD	29c. License number D0058009		Date signed (Month, Day, Year)  FTENSER 18, 2006
H		30. Name and address of person who ZELALEM MAKONA	completed cause of death (Item 23a) (Type, IEW 900 CATON AVEN	Print)		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		,	

State of Maryland / Department of Health and Mental Hygien 2005 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 19,20061159AM SEPTRABLE FLORENCE P. BANKS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A sital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2√F 216-28-0562 80 Director 05/24/1926 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f ehow the Medical Exeminer must be notified at MD N/A BALTIMORE CITY Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3706 ROSEDALE ROAD USA Funeral 14. Race - American Indian, Black, White, etc. 'natural', or itsms 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: BLACK þ ₩Vidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER DOMESTIC 8тн 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth eny liptry or other treumatic event 9DRB. Be JOSEPH GRAY LOUISE CURTIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONSTANCE D. BANKS/DAUGHTER 3706 ROSEDALE RD., BALTIMORE, MD 21215 20b. Place of Disposition (Name of MD VETERANS CEM. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/28/06 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Eneral Service Licensee HOWELL FUNERAL HOME 21207 22. Name and Address of Facility 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease of condition resulting in death)

a. 

\*\*DISTANCE:\*\* THE IGHT'S AV Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STENTS 1 Yes 2 No 3 Probebly 4 Junknown GASTRU INTESTINAL BLERDING 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ULCER 1 Yes 2 0 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2.☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗆 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D0051865 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPIM BATIMORE CURTTS ST AGNES HARLES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of I	Marylan		artment of l		nd Mental H	ygiene	2006	29886
Physic /Medi Exami	cal	LUCY  4a. Facility Name (If not institution, Glen Burnie H	LILLIAN give street and number	er)	OSGRO	VE 4b. Cily, Town, G1en E		2. Date of Month Sept	19 2 4c. Co	Year 006 unty of Death e Aru	
Funeral Director		229-16-4919	5. Sex 1 □ M 2  F 7.	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of April	Birth (Pear)	9. Birth	place (State or Foreign ntry) rginia
ne Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A	1	10c. City	, Town or Lo Balt	imore					10d. Inside City Limits 1   Yes 2   No
uth with the 23a or 2 ust be no	Funeral Director	1207 Riverside	Avenue			10f. Zip Code 21	230		10g. Citizen U.S	of What Cou	intry?
perilliore, Interview A. 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at appare.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	No	1	Vas Decedent of f Yes, specify Cub		n? (Specify Yes or Puerto Rican, etc.)		Race - Ameri Black, White, ecify: Whi	, etc.
d within 72 h giene. er than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4e	or 5+)	(Give lite. L	lent's Usual Occu kind of work done DO NOT use retire eamstres	i during most o ed)	f working		of Business/Ir	
yidilu ouid be file Mental Hy warked oth	To Be (	17. Father's Name (First, Middle, L. William	T. Brown	n			Ma		L. M	i1by	
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Dallillor  ermit. Pages Depertment of mportant: if it iny injury or o		1  Burial 2  Cremation 3  Constitution 5  Other (Specific Constitution 5  Other (Specific Constitution Const	ecify)	. C	dar Hi	11 Cemet	ery 09	9-22-06	1		k,Maryland
Dermi Depe Impo Impo		21. Signature of Funeral Service Li 234 art 1. Enter the disease, or c shock, or heart failure. List o	Hour	sed the death	$\frac{1}{23}$	er the mode of dy	olyniak apsco A ing, such as ca	rdiac or respiratory	arrest,		yland21225 Approximate Interval Between Onset and Death
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The column, T.C. DOX 00/00, C.  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⑫ No 9 □ Unknown		1 2 ☐ Fetal t at time of de	death 3	Ectopic pregnand Other (specify)	Çy .		23d.	. Date of deliv Month	ery Day Year
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ding Physician: The I ding Physician: The I h. After this certificate he funeral director, page	To Be	25. Was case referred to medical examiner?  1 Tyes 2 DNo			ER/Outpatien	t 3 DOA Ot	her: 4 [] Nursi	f Death Check onling Home 5 Re	sidence 6 🗆		fy)
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the Hosp in 24 hou the Fune ipletely fi	Medical	(Check only 2 Medicaf E. one)	Physician: To the be kaminer: On the basis and manner	s of examinat	wledge, death tion and/or inv	restigation, in my	opinion, death	place, and due to the occurred at the time	e, date and pla	ce, and due t	o the cause(s)
To To Com	2	29b. Signature and title officertifier	allen				se number	0		gned (Month,	
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			_ For	State	of Maryland / D	epartment of H	lealth and M	lental Hygien	eanne	20007
			1 - Stata Registrar			Certificate of I	Death	Reg. N	6.2000	23001
	Physici		1. Decedent's Name (First, M		les			2. Date of Death Month Death	19 Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not instit			4b. City, Town, or	Location of Death		c. County of Death	
1	Francis		University of  5. Social Security Number	Maryland	7. Age (In yrs. last bin		MORE (	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		219-38-5886	5 1□M 2×F	/ 1	Yrs. Months Days	Hours Min.	12-24 P	841 Cou	intry) N
	yland		Usual Residence of Deceden 10a. State 10b. Con		10c. City, Town	n or Location				10d. Inside City Limits
	Ba-f et	ector	MD B	saltimore	- Owi	ngs Mill	ی			1 Tes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then "natural", or iteme 23a or 28e-f ehow appropriately or other traumatic event, the Medical Examinar must be natilised at once.	Funeral Director	10e. Street and Number	nber Gr	ove Roa	10f. Zip Code	1117	10g. 0	Citizen of What Cou	intry?
	teme 2	unera	11. Marital Status	12. Was Dec Armed F	sedent Ever in U.S. orces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
020	hours after tural', or ite al Examine	by	1 Never Married 2 3 Widowed 4 Divo	If Yes G	274No ive Dates:	1 ☐ Yes 2 No	Specify:		Specify: B	ack
<u>0</u>	"natur	Completed		edent's Education ighest grade completed,	16a.	Decedent's Usual Occupa (Give kind of work done) life. DO NOT use retige	turina most of work	ing 16b.	Kind of Business/le	Security
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aryi	should and Mer marke umatic	Ţ	19a. Informant's Name/Relat	tionship (type, Print)	19b.	Mailing Address (Street	and Number of Jur	a/Reute Manaber, City	or town State, Zi	p Code)
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	Pages 1 nent of H int: If Ite		20a. Method of Disposition  1 Burial 2 Cremat  4 Donation 5 Dothe	ion 3 Removal from	/ comotor	y, crematory or other place		-06	Location - City or T	own, state
Бантто	Departm Departm Importar any Injur			vice zicensee	Out	23 Name and Address	Fac Gre	ene Fund	ral Se	rices
	405 E 9		23a. Part1. Enter he liseas	e, or complications that	caused the death. Do r	8728 Libe	g, such as cardiac		wniMD	2)133 Approximate
	Physician		shock, or hear illure. Immediate Cause (Final disease or condition	List only one cause on	each line.	rrhosis	_		1251	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to	(or as a consequence		> 1   111	1819 01	1019	
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0	death c e attend d for us	Physician/Med	23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 ☑ No	¹ 1☐Live 4☐Preg	itcome of pregnancy birth 2 ☐ Fetal death nant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive	ery Day Year
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cords,	tuires the signer of signe	Completed by	Part II. Other significant con Hepa-toce	llular	0 1	ma_	en in Pan I.	1 ☐ Yes	/	bably 4 □Unknown
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T	n: The licate h r, page			7 7.				performed?	/ death?	
VII.	ysicial is certii directo	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 ER/Ou	tpatient 3 DOA Othe	or	h (Check only one) me 5 ☐ Residence	6 □Other (Spec	fy)
0 0	ling Ph After th uneral		27. Manner of Death 1 Natural 5 □ Pe			ime of 28c. Injury Work	at k?	28d. Describe how in		,,
VISION	Attender death	Certification:	3 ☐ Suicide 6 ☐ Co	vestigation ould not be stermined 28e. Plac	e of Injury - At home, fa	M 1 □ ' rm, street, factory, office	Yes 2 □ No	28f. Location (Street	and Number or Rui	al Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier 1 <b>Carl</b> (Check only 2 <b>Med</b> one)	ical Examiner: On the b	e best of my knowledge basis of examination and oner stated.	, death occurred at the time d/or investigation, in my of	ne, date and place, pinion, death occuri	and due to the cause red at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the To the comp	Σ	29b. Signature and title of ce	rtifier 1		29c. License			ate signed (Month	Day, Year)
	16		30. Name and address of per	rson who completed cau	se of death (Item 23a)		76435	B17396	9/19	1/06
	1.5		450	S' Bai	con 11	77 5 /- VA	ne Stre	et Balti	nare, H	D 21201
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#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 2006 29888 1. For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day Y September 17, 2006 Medical Examiner 2257 hrs Curtis Edward 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Months Days Hours oreian Director Country) 217-23-6822 1**X** M 2 02-24-1989 Md. Usual Residence of Decedent 10a. State 10c City, Town or Location 10d. Inside City Limits 1 X Yes 2 28a-f show Baltimore NA Md. with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country notified at USA 21205 2409 McElderry Street or items 23a Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian, Black death v Armed Forces? 1 XNever Married 2 Married White, etc. Yes hours after Widowed 4 Divorced f Yes, Give Year 1 Yes 2 No specify Specify. Black "natural", ゑ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) mit. Pages 1 and 2 should be filed within 72 l partment of Health and Mental Hygiene portant: If item 27 is marked other than " ury or other traumatic event, the Medical E Baltimore, MD 21215-0036 NA 10th grade Unemployed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Curtis, Jr. Cassandra Antoine McCrav Antonio Edward 19a Informant's Name/Relationship (Type, Print )
Cassandra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 McElderry Street, Baltimore, Md. Mother <del>Cassabdra</del> -A. McCray 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c Location - City or Town, State XBurial 2 Cremation 3 Removal from State 9-22-06 Baltimore, Md. New Cathedral Cem. Donation 5 Other Specify 21 Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. ) an 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED X AMENDED item#19a,perFH,C859,9/26/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has t performed? death? certificate Yes 2 1 🗸 Yes 2 No the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? lospital 1 Other<sub>4</sub> DOA Nursing Home 5 Inpatient 2 FR/Outpatient 3 Residence 6 this 2 1 Yes 2 No. 28a. Date of Injury (Month, Day Year) Sep 17, 2006 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 Natural 2202 hrs s after death Pending Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 3700 Block of East Baltimore Street, Baltimore, 4 V Homicide determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 18, 2006 30 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State 2006 Registrar

		1 - For State Registrar	State of	of Maryland		artment of tificate o				giene Reg. No.	06	29889
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Funera Directo		5. Social Security Number 218–28–3398	6. Sex 1 <b>⊠</b> M 2 ☐ F	7. Age (In yrs. last <b>73</b>	t birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day 05/25/	/, Year) /1933	9. Birthpl Count	ace (State or Foreign try) MD
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<b>Baltimc</b> permit. Pag Department Important: It any injury o		21. Signature of Funeral Service	censee	1		. Name and Add	lress of Facilit	ty WES	SLEY CH	AVIS, JI	R. FN	RL. HM.
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/Medica Examine			Due to	(or as a consequen	ice of):							
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Tad page	þ	Part II, Other significant condition	ns contributing to d	eath but not resultin	ng in the ur	nderlying cause (	given in Part I.			bacco use contr		e cause of death?
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To the Hos within 24 h To the Fun completely	₹	29b. Signature and title of certifier				29c. Lice	nse number		2	9d. Date signed	(Month, D	Day, Year)
15		Heorge	C. Wr	il M	MD	DZ	11365	5	5	eptemb	ier l	6,2006
5		30. Name and address of person Geovar E, Wi	who completed caus	be of death (Item 23 D. 390	la) (Type,	SEL R	2 ven B	oule	vent, F	Baltimi	me, M	P. 21218
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 2 1	32 <sup>3</sup> F	Registrar's Signature		all I						

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinating must be inclifted at once.	najaidu	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Grade completed)  College (1-4or	5+)	16a. Deced (Give k life. D	ent's Usual and of work O NOT use	k done durir	n ng most of w	orking	16b. Kind of Busine	Tee
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Tand 2 show Health and A Health and A Health and A Health and A Health are trauma	-	19a. Informant's Name/Relationshi Sylvia Watkins/f 20a. Method of Disposition		20b. P		ennsy	lvani		Rural Route Number nue Balti Date	more MD  20c. Location - City	21201
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To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	2	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending		ury	ER/Outpatient 28b. Time of Injury		Other: Bc. Injury at Work?			ence 6 □Other (S ow injury occurred	pecify)
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To the Within To the Comp	2	29b. Signature and title of certifier	y placen	n /	MD	D	License nu	503		29d. Date signed (Me Septemb	onth, Day, Year) e/ 11, 2006
		30. Name and address of person w	ho completed cause of a	death (Item	n 23a) (Type, F	Print)	S)-,	B-1,	t mp	21243	
State Registra	9	31. Date filed (Month, Day, Year) SEP 2 1 20	32. Registi	rar's Signa	ature	A A					

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			1 - For State Registrar	State of Maryland	nent of Health and Mental Hygiene cate of Death Reg. No. 2005 2989					
	Physici	an	1. Decedent's Name (First, Middle,	Last)			2. Date of De. Month			
	/Medi		Brooke	Conaway			Septemb	er 18 2006 11:20	Ам	
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	or 28	Director	10e. Street and Number			f. Zip Code		10g. Citizen of What Country?		
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m O	0 0 = =		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec	□Removal from State	metery, crematory	or other place)		44		
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lic	FULL	22. Nam	ne and Address Facilit	ptenber 18, 2006 V Anatomy Gift	Hanover, MD		
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8760,	Physician /Medical Examiner e prusal e prusal lausil	cai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Securitary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	-	ence of): ence of):	ESLETABLE	Agenocan	Interval Batween Onset and Deat	TA TABLE	
P.O. Box 687	I he law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	23c. If yes, outcome of pregnan- 1 Live birth 2 Fetal c 4 Pregnant at time of dea 9 Unknown	death 3 ⊟Ectop ath 5 ⊡ Othe	oic pregnancy r (specify)	23a Did te	23d. Date of delivery  Month Day Year		
ds,	signe of ble	d by	ANEMIA					Yes 2 No 3 Probably 4 Nonknown		
i S S	law requir as been si 2 should	Completed		-			24a. Was a	a. Was an 24b. Were autopsy findings availa		
R		Com					autop perfor 1 \( \text{Yes}	med? death?	of	
/ita	e iji	Be	25. Was case referred to medical examiner?				of Death (Check only or	ne)		
	ding After fune	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	(Month, Day Year)	R/Outpatient 3 28b. Time of Injury M	DOA Other: 4 Nui 28c. Injury at Work? 1 Yes 2 1	28d. Describe h	lence 6 Sother (Specify) 455 157 A		
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not determine	286. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)			28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifying F (Check only one) 1 Certifying F 2 Medical Ext	ng Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.				cause(s) and manner as stated.  date and place, and due to the cause(s)		
	To Te Co	Σ	29b. Signature and title of certifier	<b>1</b>		29c. License number	Z	29d. Date signed (Month, Day, Year)		
7			Sift an &	onto mo	20-1/47	D005139	5	9/18/2006		
ク			William E 72	The Man IIIIO IV.	ZJa) (Type, Print)	AMAS RO	SVIZE 107	Harris 201	2	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Jegistrar's Signatu	* Spen	Ü		9/18/2006 HACKISTOWN MO		

06-06602 Eugene Cass

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

3

		1- For State Registrar  Certificate of Death Reg. No. 2006	2000						
Physicia Medical Exami		I Month Day Year I .	ime of Death U 2						
-	1101	Eugene Cass September 3, 2006  4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death 4c. County of Death	37 3, 2000						
		Prince George's Hospital Center Cheverly Prince George's							
Funeral Director		1 M 2 F 60 Yrs. Months Days Hours Min. Feb 24, 1946 Foreign Country	Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or unkel)  eb 24, 1946 Country)						
any	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits						
<b>*</b>		MD Prince George's Hyattsville	Yes 2 No						
Maryland 28a-f show d at once.		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							
th the Maryland 23a or 28a-f sho notified at once.									
or items	Funeral		ndian, Black, .ack						
ours aft Itural' amine	To Be Completed by	or Dates:							
		Elementary/Secondary (0-12) College (1-4 or 5+) unk during most of working life. DO NOT use retired)	,						
			unk						
MD  od 2 sho  ulth and m 27 is aumati		O.C.M.E. 111 Penn Street Baltimore, MD 21201							
Baltimore, permit. Pages I ar Department of Hee Important: If ite		20a Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town or Town or Other place)							
Balt permit. Depart Import		21. Signatur r Euneral Se, icel icensee Ronal S. Wade Director State Anatomy Board 655 W. Baltimore Street paltimore, MD 21201							
Physician /Medical		3a. P nt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and							
Examiner		Immediate Cause (Final disease or condition resulting in death)  Diabetic ketoacidosis  Due to (or as a consequence of):	Death						
Due to (or as a consequence of):  Sequentially list conditions,  b									
	iner	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause  Comparison of the control of the							
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit									
760, ficate be e g physicia the burial	/Medical	item#23a,27,perME,g859,9/22/06 TT    AMENDED   item#23a,27,perME,g859,9/22/06 TT   23d Date of delivery							
6876 ertificat ding phy	an/N	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year						
Box 68 death certif	Physician	4 Pregnant at time of death 5 Other (Specify) 9 Unknown							
D.O. Be that the de detached f			ause of death?						
, P.O.	d by		4 Unknown						
cords law requi	ompleted	24a. Was an 24b. Were autopsy autopsy prior to comple	findings available etion of cause of						
RecC The lar	mo	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No						
Vital Rec ysician: The his certificate	Be C	25. Was case referred to medical 26. Place of Death (Check only one)							
n of Vital I ding Physician: h : After this certifi funeral director,	P	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Out 4 Nursing Home 5 Residence 6 Other.							
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
ViSion Parte de fiter de Directo in by t	ifica	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Ro	oute Number, City						
Divi Spital or tours afte neral Dir filled in	Cert	4 Homicide determined (Specify) or Town, State)							
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical	29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated							
		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed (Month, Date signed (Month, Date signed (Month), Date signed	ay, Year)						
		tate Granica - Pollelia O.C.M.E. September 4, 2006							
		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
St	ate	g 31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regist	rar	SFP 2 1 2006							

			1 - For State Registrar	State of Man	/land / Depa		lealth and l		iene	06 2989	
, /N	ysicia ledica amine	al -					2. Date of Month Sept.				
Fund Direct			3006 Argentina P1 5. Social Security Number 6. Security Number 151–24–0326	7. Age (li	n yrs. last birthday) 74 Yrs.	Bowie  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 12,		9. Birthplace (State or Foreign Country) New Jersey	
the Maryland	notified at	rector	10a. State 10b. County  MD Prince 10e. Street and Number	George's	oc. City, Town or Lo Bowie	tof. Zip Code		10	ng. Citizen of Wh	10d. fnside City Limits 1 ☐ Yes 2√ No nat Country?	
DENTITIONE, MARY/IGING Z.I.Z.I.3-UU.30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show	MINEL THEE DE	/ Funeral Director	3006 Argentina P  11. Marital Status  1 Never Married 2 Married	1ace 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give		Was Decedent of H		pecify Yes or No- o Rican, etc.)	Black,	American Indian, White, etc.	
Z1 5-UU3 ithin 72 hours nen 'neturel',	Medical Exa	Completed by	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	16a. Deced	I ☐ Yes 2 ☑ No  Ient's Usual Occup kind of work done of NOT use retired	Specify:  ation during most of wor	king	Specify: \	white	
Maryland 21215-0036 nd 2 should be filed within 72 hours aff lith and Mental Hygiene. 27 is marked other than "natural", or	atic svent, in	To Be Cor	12 17. Father's Name (First, Middle, Last) Dennis Peter Carr	011	sale	sperson	18. Mother's Nar Anna Be	ne (First, Middle, M		equipment	
OFE, Mar es 1 and 2 sh of Health and fitsm 27 is m	r other trsum		19a. Informant's Name/Relationship (Ty, Dennis P. Carroll  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	/son	3006 20b. Place of Dispo	Argentin	na Place	Bowie, MI	20716	ate, Zip Code) ity or Town, State	
Baltimore, permit. Pages 1 ar Department of Hea Important: If itsm	eny injury o		4 Donation 5 Other (Specify)  21. Synature Luneral Service License Ronald		or 22 S	. Name and Addrestate Ana	ss of Facility LOMY Boan		Baltimo	ore Street	
Pnysic /Medi		shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death		
ite be executed EXE	e Durial-transit	cal Examiner	Sequentially list conditions, it is a list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to lor as a co	onsectuentia of):						
The law requires that the death certificat ate has been signed by the atlending phy	or use as in	Physician/Medi	IF FEMALE:	3c. ff yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,	
he law requires that e has been signed by	9	<u>`</u>	Part II. Other significant conditions con Seizures							to use contribute to the cause of death?  2 No 3 Probably 4 Onknown	
vicion: The law certificate has b	7 8080	e completed	25. Was case referred to medical	26 Place of Deat			perform	autopsy performed? prior to completion of cause of death?  Yes 2 No 1 Yes 2 No			
ing Phys	a numeral allec	aci : lo a	examiner? 1	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Holland   28a. Oate of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?			lome 5 Hesidence 6 Other (Specify) 28d. Tescribe how injury occurred				
E Hospitel or Attending 24 hours after death.		Certification:	3 Suicide 6 Could not be determined	eet, factory, office  28f. Location City or 7		City or Town,					
To the Hos within 24 ho To the Fun	compreheny miled in by	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	ner: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	estigation, in my op	oinion, death occu	rred at the time, da	te and place, and	er as stated. If due to the cause(s)  Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						Sept 15, 2006		
Rec	State		Martin Weltz MD 7. 31. Date filed (Month, Day, Year)  SEP 9 1 200	32. Registrar's	y Ctr Dr Signature	#205 Gre	enbelt,	MD 20770			

06-06604 Michael Cole Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 2006 29895 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day September 3, 2006 Medical Examiner 1936 hrs Michael Cole 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3 North Kresson Street Baltimore 5. Social Security Number unk6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** oreign Director Months Days Hours Country Maryland 1 X M 2 F 32 Yrs 1974 Jan 24, Usual Residence of Decedent any. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show r must be notified at once. Yes 2 No MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene Baltimore Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 3 North Kresson Street 21224 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Married White etc 2 X No Yes Divorced If Yes, Give Year Widowed Yes 2 X No specify Specify "natural". ⋧ black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical other than Baltimore, MD 21215-0036 0 disabled none 17, Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) unk is marked traumatic event, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracina Edge/adopted sister 2429 Ashland Avenue Baltimore, MD If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State permit Pages I a
Department of He
Important: If ite
injury or other ti crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 21. Si rature of Fureral Service Lice Wide, Director 32 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** ailure. List only one cause on each line. Between Onset and /Medical Myocarditis and pneumonia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and ed for use as the burial - transi Physician/Medical X UNPENDED AMENDED item#23a,27,perME, 860,10/2/06 TT Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other 4 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 4, 2006 30 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [6] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ep ferner **Physician** Ronald M. Damico /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) July 1, 1948 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 58 220-50-1185 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits other than "natural, or items 23a or 28a-f show vent, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 Willow Oak Road 21234 **USA** Peges 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory Uth and Mental Hygis 27 is marked other in traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald E. Damico ည Margie Reilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Ronald E. Damico, Father 8620 Willow Oak Road Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of P Important: If its eny injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 09/19/06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. Rame and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregory 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate interval Betwe Sastrondertial Riee Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or all a consettending physicien and for use as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificete has t irector, page 2 s autopsy performed? Yes 2 No 1 Yes or Attending Physicien: : After this certifice e funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 21 No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation after death.
I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire 4 \ Homicide o the Hospital Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier

State Registrar

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30. Name and a dress of person

31. Date filed (Month, Day, Yes SEP

Hum

of death (Item 23a) (Type, Print)

voluna HAD

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 29897 1 - State Registra Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** SEP 20, 2006 10:27 A<sup>M</sup> Elizabeth J. Dunne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons Solomons Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 8, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1□M 2√2F 83 Yrs. 081-14-7905 NY Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 7 is marked other than "natural", or items 23s or 28s-1 shor treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ➡ No Director Calvert Solomons 5 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20688 13325 Dowell Rd USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other treumatic event, the Medical Elementers ADRE. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give A Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Specify: White If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Burns Mary Martin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary K. Anderson/daughter 1014 University Forrest Dr Conway, SC 29526 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/21 - 06 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. Tolor. 200 Frederick Rd Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEMONIA **Physician** /Medical Examiner Metastatic Breast CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division of Vital Records, P.O. Box 68760. ettending physician and for use as the burial-transil Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detech Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ONGESTINE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy hes 2 No certificate 1 ☐ Yes After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No Certification: To 1 Tyes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the within 24 hours efter deatl To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Rd Site 310 Prince Frederick MO 20678 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. degistrar's Signature 31. Date filed State Registrar

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AOUS Month **Physician** ARCEL 2006 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAL If Under 24 F BALTIMURE REHABILITATION EXTENDED CARE MORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1√2 M 2□ F Hours 89 Director 007-03-7409 June 16, 1917 Maine Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Itame 23e or 28e-f ehow Tre Medical Examiner mout be rediffed at 1 Yes 2 No Director MD Baltimore White Marsh 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11010 Bowerman Road 21162 United States deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: Specify: þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Management Manager permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Itam 27 I e marked other eny injury or other treumatic event, 900.68. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J.O. d'Aoust Clementine Peloquin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11010 Bowerman Road, White Marsh, MD 21162 Michelle d'Aoust, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph's Cemetery 08/18/06 Biddeford, Maine 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Independent Death Care of Maine M01113 471 Deering Avenue, Portland, Maine 04103 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE -0 CH 31. Date filed (Month, Day, Year) State SEP 2 1 2006 Registra

State of Maryland / Department of Health and Mental Hygiene 2005 29899 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** CONAId CHARLES DAVIS August 31 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Joseph medical Conter BAltiMORE TOWSON COUNTY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F Birthplace (State or Fo Country) 5. Social Security Number 7. Age (In yrs. last birthday) 28 August 31, 2006 MARY/ANd **Funeral** Days Yrs NONE Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or iteme 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MARYLAND BALLIMORE COUNTY Directo Towson 10f. Zip Code 10g. Citizen of Whal Country? 10e. Street and Number U.S.A. 2707 BERWICK AVE. 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Exempted once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIACK by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) INFANT INFANT 0 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TwilA D. MohAmmed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUE (mother) 2707 BERWick BALLMORE Md. 21234 Twild D. Mchammed 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate Date 20a. Method of Disposition Sept. 27 1 Burial 2 Cremation 3 Removal from State BALTIMERE CITY, 4 □ Donation 5 □ Other (Specify) Holy REDEEMER CEmply 2006 MARYIAND 21. Signature of Fundal Solvice Lipinsee 22. Name and Address of Facility DRIVE OSIER 7601 la St. Jeseph Medical Center TOWSEN, 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Oligohydramnios **Physician** disease or condition resulting in death) /Medical ashormal ties Due to (or as a consequence of): Examiner YINRYY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the attending physicien and ched for use as the burial-transit monary that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnanl at time of death 5 Other (specify) been signed by the should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in lihe underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed? 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury al Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. •he Funerel F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiel Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 D28244 September 6, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) TA9: Osler Deve Towsing Md. 2,204 "OWZIA 7601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygieney 29900 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** llian Hugust DOAK 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death thills atonsville Baltimore Kolling If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Міл. 1 ☐ M 2 🔀 F Director 302-10-1312 95 Mar 4, WV Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examinar must be potified at 10d. Inside City Limits Be Completed by Funeral Director 1 ☐ Yes 21 No Baltimore Catonsville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item any highy or other traumatic event. 305 North Rolling Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 saleslady retail clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Henry Snapp Hattie Bell Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Massanutten Manor Cir. Spranburg, VA 22657 Colleen McCarty/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ADonation 5 Other (Specify) 21. Signature of Funeral Servic Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Director 655 W. Baltimore Street ann 2da. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence disease /Medical of): Examiner 1Dertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or)as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed dystipidemia Due to or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. Il Director: A 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dea To the Funeral Director completely filled in by th 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of cerufier 29d. Date signed (Month, Day, Year) D0059914 September 11, 2006 mpteled cause of death (Item 23a) (Type, Print) Baltruore DURST 1120 Maryland 2122 TERGE 32, Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 SEP 2 Registrar

			1 - For State Registrar	State of Ma	arylan	-	artment rtificate					iene .g. No.20	06	299	301
	Physic /Medi		1. Decedent's Name (First, Middle, Last  James S. Ent, J	r						s	Date of Deat Month	Day 13,200		3. Time of 8:22	Death M
	Examir Funeral	ner	4a. Facility Name (If not institution, give  SALISBURY REHAB  5. Social Security Number 6. Se	& NURSII		NTER ast birthday)	If Under 1	LISE	URY,	MD. 2	1804	4c. County	ICOMI	CO lace (State or	r Foreign
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	ith the Marylar or 28e-f show	Director	MD Wicomic	0	5	Salisb	ury	Code			10	Og. Citizen of		1 🗌 Yes	1
036	n 72 hours after death with the Maryland "neturel", or items 23a or 28e-f show calcal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:		1	Was Decede f Yes, specif 1 Yes 2			.804 gin? (Specify i, Puerto Rica	Yes or No- n, etc.)	14. Rac Bla	JSA ce - Americ ck, White, o y: Whi	etc.	
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Maryland	2 should be filed and Mental Hygi ie marked other eumatic event, II	To Be	17. Father's Name (First, Middle, Last) $James~S.~E$ 19a. Informant's Name/Relationship ( $\mathcal{T}_J$ )			19b. Mailin	g Address (					faiden Suman City or Town,			unk
Itimore, M	pes 1 an of Heal If item 2 or other		Salisbury Rehab &  20a. Method of Disposition  1  Burial 2  Cremation 3    4  Donation 5  Other (Specify)	Removal from State	20b. PI	200 ace of Disposemetery, cren	sition (Name	e of		Salisbu Date	-	D 2180		wn, State	
Balti	permit Pag Deparment Importent: any injury o		21. Signature of Femeral Service Licens Ronald	Jaky Dire	ctor	Ra	1timo	re.	MD 2	21201		Baltim	ore S	treet	
	Physician // // // // // // // // // // // // //	dlcal Examiner	2.a. in 1. Enter the disease, or omp ship or heart failure. List only of Immediate Cattle (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	e. a consequ a consequ	ence of):	er the mode	of dying,	lan 1	Cardiac or res	a La	Seel s	y Z	Approximate Interval Betwonset and D	<b>ve</b> en
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م	w requires that the back of th	by P	Part II. Other significant conditions co	ntributing to death bu	t not resu	iting in the un	iderlying cau	use given	in Part I.			acco use cont		e cause of de	
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of	ding Phyeici n. After this cer funeral direct	on: To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1  lnpatier 28a. Date of Injun (Month, Day		ER/Outpatient 28b. Time of Injury		Other: c. Injury a Work?	4 Hur	28d.	5 Residen	) ice 6 □Oth v injury occurr		1	
=	o in Dir	Certificat	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	. (Specify)					(	City or Town,				er,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier   1 Certifying Physical Exami   2 Medical Exami   29b. Signature and title of certifier   2 Certifi	sician: To the best of ner: On the basis of and manner stat	examinati	vledge, death on and/or inv	estigation, ir	the time n my opir License r	nion, death	l place, and d h occurred at	the time, dat	use(s) and ma e and place, a d. Date signed	and due to	the cause(s)	
)	- <b>5 =</b> 0		30. Name and address of person who co	ompleted cause of de	ath (Item	23a) (Type, F		2	93	49		8/13	186		
	Sta Registr		WILLIAM ROBINS, M. 31. Date filed (Month, Day, Year) SEP 2 1 2006	#32. Registra	r's Signatu	AVE - /		BURY	MD.	2180	14				

			1 - For State Registrar	State	of Maryla	nd / Depa	artment of F rtificate of	lealth and Death	Mental Hy	giene 2 () Reg. No.	06 29902
п	Physici	an	Decedent's Name (First, Midd.						2. Date of De Month	Day	3. Time of Death
	/Medi	al	Sister Mary J  4a. Facility Name (If not institution				th City Town o	r Lagation of Da		er 6, 20	
	Examir	er	The Villa	i, give street and m	umberj		4b. City, Town, o Baltimo		atti	4C. County C	Death
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th	Birthplace (State or Foreign Country)
	Director		220-54-8356	1□M 2∏F	85	Yrs.	Months Days	Hours Mi	n. Aug 3,	1921	Maryland
	pu k		Usual Residence of Decedent  10a. State 10b. County	-	100.0	ity, Town or Lo	cation				10d Inside City Limits
	anyla •ho	ō	MD 100. County		100.0	Baltir					10d. Inside City Limits 1√2 Yes 2 □ No
	death with the Maryland ems 23a or 28e-f ehow if must be notified at	Funeral Director	10e. Street and Number			Darti	10f. Zip Code			10g. Citizen of W	21
	with with	ᅙ		Ch				1 201			nat Country:
	death	era	13 S. Poppleto	12. Was Dec	cedent Ever in I	J.S. 13.1	Was Decedent of H f Yes, specify Cuba	1201 lispanic Origin?	(Specify Yes or No	USA 14. Race	- American Indian,
936	or its		1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	Armed F ned 1 ☐ Yes If Yes, G Year or I	2X No		fYes, specifyCuba 1□Yes 21ሺ No	Specify:	erto Rican, etc.)		, White, etc. White
2-0	72 hours nature!,	ted	15. Deceder	t's Education st grade completed,	1	16a. Dece	dent's Usual Occup	ation	unk	16b. Kind of Bus	iness/Industry unk
Maryland 21215-0036	be filed within 72 ho stal Hygiene. of other than "natur event, the Medical	Completed by	Elementary/Secondary (0-12)		(1-4or 5+)	lite.	kind of work done DO NOT use retired	during most of w	rorking		
9	be fife tal Hy d oth	Bec	17. Father's Name (First, Middle,					18. Mother's N	ame (First, Middle	, Maiden Sumame	)
yla	2 should be and Mental ie marked o aumatic ev	2	Herbert Erski		S				May Duke		
Mar	s 1 and 2 should 1 Health and Mer Itam 27 is marks other traumatic		19a. Informant's Name/Relations	hip (Type, Print)			g Address (Street				
	1 and Healtl am 27 ther 1		The Villa  20a. Method of Disposition		20b.		Bellona A	venue B	Date		it Z
Baltimore,	Page nent o ant: if ury or		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S	pecify)	State	cemetery, crer	natory or other plac	ce)		zoo. coodiion	ny or rown, state
Ball	Depertition Depert		21. Signature of Funeral Strice	b. Wade, I	Directo		tate Mara	•	ard 655 W 201	. Baltimo	ore Street
			23a. Part1. Enter the disease, o shock, otheart failure. List	complications that	caused the dea	th. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		Seps	15					Onset and Death
1	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):					20073
	_ Xaiiiiici	e	Sequentially list conditions,	b	fail	me )	to thre	've			170
	nsit	nlne	cause. Enter Underlying Cause (Disease or injury	T	d. w. c.t.		rombo t	t di solo	illo laika.	- Witt	2 Test
<u>.</u>	execunand nand ial-tra	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conse		NOW BO THIS	of	100	a with splanom	are.
68760,	ificate be executed g physicien and as the burial-transit	edical		d							00
Вох 6	E On ai		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of pregr birth 2 ☐ Fet	ancy	Ectopic pregnancy			23d. Date	of delivery
P.O. B	that the dea led by the att	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nant at time of		Other (specify)			Mont	h Day Year
Records, F	The law requires that the death cert site hes been signed by the attendin bage 2 should be detached for use	þ	Part II. Other significant conditi	ons contributing to c	death but not re	sulting in the u	nderlying cause give	en in Part I.			oute to the cause of death?
Ö	s bee	olete							24a. Was	an 24b. W	ere autopsy findings available
- Re		Completed								osy pri ormed? de	or to completion of cause of ath?  Yes 2 No
/ita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of D	eath (Check only o		
£	Physic this c	ို	1 ☐ Yes 2 ☐ No		Inpatient 2			4 🔁 Ivursing	Home 5 ☐ Resi		
O	ding f th. After tuner	tlon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pendir  2 ☐ Accident investi	9	of Injury oth, Day Year)	28b. Time of Injury	28c. Injun Worl	/at <br Yes 2∐No	28d. Describe I	now injury occurred	d
Division of Vital	ii or Atter efter dea i Director d in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place	e of Injury - At h ding, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location ( City or Tox	Street and Number vn, State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours elter death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	g Physician: To the Examiner: On the band man	e best of my knoasis of examin	owledge, death ation and/or inv	occurred at the timestigation, in my of	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and man date and place, an	ner as stated.  d due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifie				29c. License		I	_	(Month, Day, Year)
			Mign-1	K. son	gm 1		0	31865		9/12	1/06
			30. Name and address of person Rm 206	who completed cau 82/		m 23a) (Type,	Print) Street	Bal	Etimore	md:	21201
	Sta Registr	_	31. Date fited (Month, Day, Year)	32. F	Registrar's Sign	ature			<del></del>		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

			1 - State Registrar	•		Certific	ate of	Death	•	Reg. No.			
	D1		1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath 1 Day 7	Year	3. Time of Death	
	Physici /Medic		Benjamin Lewis I	ranklin					Septer		2006	5:457	М
	Examir	ner	4a. Facility Name (If not institution, giv	4 11 1	1 1. 1		0 1	r Location of Death	1		ty ol Death	. 11	
				notan Mucha	1 Coft		nen	BURAL		Hnn	-	under	
	Funeral			MA OFF	yrs. last birt	rrs. Mon	ths Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 01/08	irth <i>ay</i> , Yea <i>r)</i>	9. Birth	place (State or Foreigntry)	ign
	Director		Usual Residence of Decedent		35				01/08	/1921		MD	
	yland		10a. State 10b. County	100	c. City, Town	or Location						10d. Inside City Limit	its
	Mar B-f-et	ţċ	MD Anne Ar	undel	Mille	rsvil	Le					1 ☐ Yes 2 🛣 N	VO.
	th the	ire	10e. Street and Number			101	. Zip Code			10g. Citizen o	What Cou	intry?	
	death with the Maryland ms 23s or 28s-f show frount by notified at	ai	644 Cecil Avenue	North			2110	8		U.	S.A.		
5	after death with the Marylan or Items 23e or 28e-f ehow refres over the notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was D If Yes,	ecedent of H specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	o- 14. Ri	ace - Amer ack, White	ican Indian, , etc.	
117. 136	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 🗆 Ye	s 2½ No	Specify:		Spec	ity:	Black	
- 2 S	within 72 hours after ene then "nature!, or ite te Mexical Examina	ed t	15. Decedent's Ed	<u> </u>	16a	Decedent's	Usual Occup	nation		16b. Kind of	Rusinass/l	dustry	
2 5	n n	Be Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)		(Give kind o life. DO NO	f work done	during most of word)	king	TOD. KING OF	D03111 <del>0</del> 33/11	luustiy	
25		E	Elementary/Secondary (0-12)	College (1-4or 5+)	Co	rrecti	ional (	Officer		State	of Ma	aryland	
_ P	be filed stal Hygie od other	3e C	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle	e, Maiden Suma	ıme)		
Ja E	should be ind Mental in marked o	2	Lewis Franklin					Agne	es Neal				
η Klin Maryland	and and ie m		19a. Informant's Name/Relationship (	**		-		and Number or Ru					П
7-000	f Health item 27 other tr		Mr. Joseph Frankl					a Court;		-			
子のかれい Baltimore, Maryland	S = 0		20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐	II IGINOVAI NOIN SIAIG	0b. Place of cemetery			1	Date	20c. Location			
/, Ë	t. Pa ntmen rtant: njury		4 □Donation 5 □ Other (Specification 4 □ Donation 5 □ Other (Specification 5 □ Other (Specific		Chesap	eake (	Cremat:	ion   09/2	26/2006	Stever	svil.	Le, MD	
Bal	permit. Page Depertment of important: if eny injury or ance.		21. Signature of Funeral Service Licer					ss of Facility Si					
			23a. Part1. Entecthe disease, or com					ve SW; G]			21061	Approximate	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	. 0	0	المارة المارة		The spiratory i	, , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	10	KEJO	1/6/	ry to	441E		-	Hars	
	Examiner			ASD 1	7) C		Phop	monio	9			Harrs	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence o	f):		111CT QC				11	
ha	cuted	Examiner	that initiated events	· Senti	2 8	hock						Hours	
,00	e exe ien a urial-1		resulting in death) Last	Due to (o as a cor	nsequence o	1):							
68760,	ertificate be executed ling physicien and se as the burial-transit	Medical	•	d							-		
×	ding p		IF FEMALE:	23c. If yes, outcome of pr	oananav								
Bo	thet the death cond by the attend detached for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death	3 ☐Ectop 5 ☐ Other	ic pregnancy	•			ate of deliv Ionth	ery Day Year	
o.	the d y the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	or death	3 COM	(Specify)						
0	Attending Physicien: The law requires thet the death or death, octor: After this certificate has been signed by the attence by the funeral director, page 2 should be detached for us	by Physician/	Part II. Other significant conditions c	ontributing to death but no	t resulting in	the underlyi	ng cause give	en in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?	
rds	law requires as been sign 2 should be	d D							10	Yes 2 □ No	3 🗆 Prol	bably 4 Dunknow	m
0	s bee	Completed							24a. Was	an 24b	Were auto	psy findings available	le
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ital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place ol Dea				26110	
<b>2</b>	Physic this ce al dire		1 ☐ Yes 2 ☑ No		2 ER/Out	patient 3	DOA Othe		ome 5□Res	idence 6 🗆 🔿	her (Specia	(y)	
<u>_</u>	Jing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Ti	jury	28c. Injun World		28d. Describe	how injury occu	rred		
Sic	ttend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be		A. L	М		Yes 2 □No	201				
Division of Vital Records, P.O.	or Arianter of Direction by	Certification; To	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At nome, far pecify)	m, street, fac	ctory, office		City or To	Street and Num wn, State)	ber or Run	al Route Number,	
_	spital ours neral filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge	death occur	red at the tim	ne date and place	and due to the	cause(s) and n	lanner as s	tated	_
	To the Hospital or Attending Physicien: The i within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examone)	niner: On the basis of examiner stated.	mination and	Vor investiga	tion, in my of	pinion, death occur	rred at the time,	date and place	, and due t	o the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date sign	ed (Month,	Day, Year)	
			> Muc Sal	Ua			D:	32744	4	Senter	nber	18 2006	27
_	(0		30, Name and address of person who	completed cause of death	(Item 23a) (7	ype, Print)	11	4	11-	5) 2 ( -	,		
	4		MARIA GAVIRIA I	10 301 Ho	portal	W	biten	burnie	MD	21061			
	Sta		31. Date filed (Month, Day, Year) SFP 9 1 201	32. Registrar's S	ighature	of for some	-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Flickner 2006 Fumiko /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arunde Glen Burnie Anne edical Months Days Hours Min. 8. Date of Birth Mary 5 (earl) 9 24 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F Japan 214-52-7752 82 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Pasadena **Funeral Director** Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 268 Magothy Beach Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Unknown Takagi Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 272 Moagthy Beach Road, Pasadena, MD 21122 Health Robert Flickner (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 20 Sept. ŏ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if eny injury or once. Glen Burnie, Maryland Glen Haven Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Accenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Mes **Physician** a /Medical Due to (or as a consequence of) **Examiner** 201 Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed elemonla Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ed by the atter detached for u Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification; To Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 MI Inpatient 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funstal I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 46596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ho 3/sela Anble 301 Jay ashree 32. Registrar's Signature 31. Date fifed (Month, Day, Year) State 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26, per fh. 9859 9-21-06 vt.

	ian	1. Decedent's Name (First, Middle, Las Marie Rose	i <b>tem 26 per</b> State of Maryl		_		2. Date of Dea Month	Day Ye	3. Time of Death
/Medi Exami		4a. Fecility Name (If not institution, give	street and number)			Location of Deat		4c. County of E	Death
Funeral Director		902 Hingham Ha 5. Social Security Number 6. Si 217-12-5512	rbor ex 7. Age (In	yrs. last birthday) Yrs.	Pasa If Under 1 Year Months Days		8. Date of Birth (Month, Day Sept. 6	, Year) 9.	Arunde1 Birthplace (State or Foreig Country) Jaryland
Se-f ahow	ector	Maryland Anne A		City, Town or Lo Pasader		81			10d. Inside City Limits 1 [] Yes 2 2 No
23e or 2 unt be n	Funeral Director	10e. Street and Number 902 Hingham Harbo	r		10f. Zip Code	21122		10g. Citizen of Wha USA	t Country?
natural', or Items 23e or 28e-f ahow dical Examiner roust be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes Z⊠No If Yes, Give Year or Dates:		Was Decedent of H. If Yes, specify Cuba 1 ☐ Yes 25€ No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc. White
iene. r than the Me	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occupi kind of work done o DO NOT use retired Homemake	during most of wor )	king	16b. Kind of Busine	
nd Mental Hygi markad other umatic evant, I	To Be C	17. Father's Name (First, Middle, Last) Leonard Lang  19a. Informant's Name/Relationship (7)	ino (Print)	105 14-15		Edith	ne (First, Middle, I Halp	in	
Department of Health and Mer Important: If Item 27 Is marka any injury or other treumatic once.		JoAnn M. Deleon (1  20a. Method of Disposition  125 Burial 2 Cremation 3 Character of Poperal Service Licens	Daughter) Removal from State	902 H b. Place of Disponsion of the place of Disponsion of the place of Disponsion of the place	ingham Ha sition (Name of natory or other plac	rbor. Pa	sadena, Date	r, City or Town, State Maryland 20c. Location - City Elkridg	21122
nysician Medical xaminer		23a. Cart1. Enter the disease, or companied to hear failure. List only of immediate Cause (Final disease or condition resulting in death)	aUn	a ca	MION	,,			Approximate Interval Between Onset and Death
nysician and he burial-transit	ical Examiner	Sequentially list conditions, it any leading to him duate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conduction of the conduction						3,5 year
y the attending physician and iched for use as the burial-transit		resulting in death) Last	b. Due to (or as a corl	sequence of):	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
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death. stor: After this certifica / the funeral director, p	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	b. Due to (or as a cond.  Due to (or as a cond.  23c. If yes, outcome of prescribed prescribed at time of the second prescribed pres	sequence of):  egnancy Fetal death 3 color death 5 color death 6 color d	t 3 DOA Other  28c. Injury Work M 1 Y  9et, factory, office	26. Place of Dea  IT: 4 ☐ Nursing H  at ?  Yes 2 ☐ No  e, date and place, inion, death occur	24a. Was an autops perform 1 Ves 2 th (Check only one Perform 28d. Describe ho 28d. Location (Str. City or Town and due to the cared at the time, day	Month  pacco use contribute as 2 \( \text{No} \) 3 \( \text{Discourse} \)  n 24b. Were prior death 1 \( \text{V} \)  n b) n consequence w injury courred  reet and Number or n, State)	Day Year  le to the cause of death?   Probably 4 Junknown   autopsy findings available to completion of cause of   Probably 4 Junknown   autopsy findings available to completion of cause of   Probably 4 Junknown   Probab

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		1 - For State Registrar	State of Marylan	d / Departme	nt of Health and te of Death	Mental Hygie	ne2006	29906
Physic /Med Exami	cal	1. Decedent's Name (First, Middle, Last,  Betty  J.  4a. Facility Name (If not institution, give	Goodwin		y, Town, or Location of Dea	Saptember	Day Year Year 4c. County of Death	3. Time of Death
Funeral Director		MTHONIL	ing Home 7. Age (In yrs.	Month	Baltimore er 1 Year   If Under 24 Hrs Days Hours Min		ear). Coui	place (State or Foreign
he Maryland 28a-f show	Director	Usual Residence of Decedent  10a. State  10b. County  The state of Decedent of		y, Town or Location  Randall:	stown			10d. Inside City Limits 1 ☐ Yes 2 No
ore, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or itams 28e or 28a-f show other traumatic event, the Medical Examinat must be notified at	Funeral	10e. Street and Number  570   Old Court  11. Marital Status  1   Never Married 2   Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. Was Dec	ip Code  2//33 edent of Hispanic Origin? (Secrity Cuban, Mexican, Puer		Citizen of What Cour U.S. A 14. Race - Americ Black, White,	can Indian,
1215-0036 within 72 hours af ene. then "netural", or the Medical Exerting the Medical Exertin	Completed by	3 Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)	If Yes, Give Year or Dates:  Ication e completed)  College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	rork done during most of wo use retired)	orking	o. Kind of Business/In	CK idustry
Maryland 21 d 2 should be filed wi th and Mental Hygien i? is marked other th traumatic event, to	To Be Co	12th  17. Father's Name (First, Middle, Last)  Willic Gosque  19a. Informant's Name/Relation hip (Tv				me (First, Middle, Mail	nery	0.41
ore, Mary es 1 and 2 sho of Health and filem 27 is m r other traum		Carol Knott / Da	ughter 20b. F	Place of Disposition (Nemetery, crematory of	demu Ave	Clumys m	S 4 1 S 2 S 3 S	21117
Baltimore, permit. Pages 1 a Department of Hei Importent: If Item any injury or othe page.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	temoval nom state	aid Ridge (	Temetery 9/2 and Address & Facility V(   1/20+4/Rel /	alghine di	reevie Juhe	nD ral Services
Physician /Medical	0.	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	,	ode of dying, such as cardia		an mo e	Approximate Interval Between Onset and Death
icate be executed by physicien and minimizers in burial-transit	Ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Diabete Due to (or as a conseq Due to (or as a conseq	s Delli	t-īs			
Records, P.O. Box 68 The law requires that the death certifical site has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopic			23d. Date of delive	ery Day Year
Records, P. he law requires that e has been signed by	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobace	co use contribute to the	
	e Completed	25. Was case referred to medical			00 Star of St	24a. Was an autopsy performed 1 Yes 2	prior to condeath?	opsy findings available impletion of cause of
Phys r this	ToB	examiner?	28a. Date of Injury	ER/Outpatient 3 0	Other: 4 Nursing I	Home 5 Residence		y)
Division  I or Attending I after death. Director: After I in by the funer	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide determined	(Month, Day Yeer)  28e. Place of Injury - At he building, etc. (Specification)		Work? 1 ☐ Yes 2 ☐ No  ory, office	28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
DIVI To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Cneck only one) Certifying Phy	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurre	d at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier			9c. License number  D 2376	_	Date signed (Month,	10
5		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print) 2434 L	DZ376 D.Belveden	e Ap	Batto 1	18,2006 12/215
St Regist	ate rar	31. Date filed (Month, Day, Year) SFP 2.1.200	32/Aegistrar's Signa	K Speck	!	,,,,		

Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Deperment of Health and Mental Hyglene. Important: If Item 27 is marked other then "netural", or Itema 23a or 28e-f show any Injury or other traumatic event, Ite Mudical Examiner must be notified at once.

9:55 р-ш.

SEPTEMBER 19, 2006

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: After this certificate has been signed by t completely filled in by the funeral director, page 2 should be detach

LAWRENCE GALLOWAY

LAW	IKENCE WE	RNER GALL	.UWA I						September	er 19,	, 2006	1	9:55P	М
4a. Facility Name (II	f not institution, g	give street and nu	mber)		4b. Cit	, Town, o	r Location	of Death		4c	. County of D	eath		
Stella Mari	s Hospice				Timo	nium					Baltimo	re		
5. Social Security N		. Sex	7. Age (II	n yrs. last birthda	y) If Und	er 1 Year		r 24 Hrs.	8. Date of Bir	rth	٥	Birthpla	ace (State or F	=oreiar
219-03-0359		XX M 2□F	85	Yrs.	Months	Days	Hours	Min.	March 31	ay, Year) 1921	Ma	Count ryla	(v)	
Usuel Residence of							1		i tai cit o	اعدا وا	1 1 1	u y r c	a io	
10a. State	10b. County		10	Oc. City, Town or	Location					_		10	d. Inside City	Limits
Maryland	Baltimo	me e	B	Raltimore									1 ☐ Yes 2	XXX
10e. Street and Nur				di dinoi C	10f. Z	ip Code			···	10a. Cit	izen of What	Count		W
6414 Blenhe						2121	2			· og. o	USA	Oodin		
11. Marital Status		12. Was Dec	edent Eve	r in U.S. 1	3. Was Dec	edent of H	lispanic O	rigin? (Sp	ecify Yes or No Rican, etc.)	<b>)</b> -	14. Race - A			
1 Never Marri	ed XX Married	Arroed Fo XXIYes If Yes, Gir Year or D	orces? 2 No ve oates:	WII	If Yes, sp 1 ☐ Yes		an, Mexica Specify		Rican, etc.)		Bleck, V Specify:	⁄hite, e Whi		
(Spec	15. Decedent's ify only highest of	Education grade completed)		(Gi	cedent's Us	ork done	durina mo:	st of work	ing	16b. K	ind of Busine	ss/Indu	ustry	
Elementary/Secon	ndary (0-12)	College (	1-4or 5+)	Own	er er	use retired	2)			C	Chemical	Com	pany	
17. Father's Name ( Joseph	(First, Middle, La	St)	allowa	у				er's Name Marie	e (First, Middle	. Maiden	Sumame)	S	chussler	^
19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Ma	uling Addre	s (Street	and Numb	er or Rur	al Route Numb	er, City o	or Town, Stat	ө, <i>Zip</i> (	Code)	
Grace Boggs	Hartman		Wife	6414	B1enhe	im Roa	ad Bal	t.imore	e,Marylan	d 212	12			
		☐Removal from	State	20b. Place of Dis cometery, c	position (Narematory or	ame of other plac	- 1		Date	20c. Lo	imore,			
Dynis	neral Service Lic	Ken/Kes	wak	260			(	6500 \	chell-Wie York Road	defel Balt	d Funer	al H	ome Inc	:12
23a. Part1. Enter the shock, or hear	ne disease, or co rt failure. List on	mplications that of ly one cause on e	caused the each line.	death. Do not e	enter the mo	de of dyin	g, such as	s cardiac (	or respiratory a	rrest,			Approximate nterval Betwe	
Immediate Cause (	Final	GANG	RENE									(	Onset and Dea	ath
resulting in death)	4	a		onsequence of):			-					+		
Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or	nditions, imediate ilying injury	Due to	(or as a co	onsequence of):										
that initiated events resulting in death) L		c. Due to	(or as a co	onsequence of):										
		d										-		
IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		oirth 2 🗀	Fetal death	3 □Ectopic <sub> </sub> 5 □ Other (s					:	23d. Date of Month		/ ∂ay Yea	ar
Part II. Other signifi	icant conditions	contributing to de	eath but no	ot resulting in the	underlying	cause giv	en in Part	l.		obacco u Yes 2	_		cause of deal	
		· · · ·								osy ormed?	prior death	to com	sy findings ava	
25. Was case referr	red to medical					-	00.5	-45	1 Tes		1 🗆 Y	es 2	□ No	
examiner?		Hospital:		•□E5:0		Oth Oth	05		Check only o	-10	-			
1 ☐ Yes 2 🔀		101	of Injury	2 ER/Outpati		07	4   141		me 5 Resid			pecify)	HOSPIC	E_
1 Natural 2 Accident 3 Suicide	5 Pending investigate	on	th, Day Ye	par) Z80. Time Injury	M	28c. Injun Worl	yat k? Yes 2□		28d. Describe I	now injur	y occurred			

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

120/06

State Registrar

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 2.1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

DHMH 17 Rev 1/2001

**ORIGINAL** 

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

29c. License number

43725

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

			For State Registrer	State of Ma	aryland	/ Depa	artment of I rtificate of	Health ar <i>Death</i>	nd Ment	al Hygie Reg.	ne 2008	29908
	Physici		1. Decedent's Name (First, Middle, Las		resas	٦			M	ate of Death onth	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give		JOICA	<u>a</u>	4b. City, Town,	or Location of I		Ptember	4c. County of Dea	0.00
	Funeral		Johns Hopkins 5. Social Security Number 6. S	Bayview ex 7. Ag	Medica e (In yrs. last	t birthday)	If Under 1 Year Months Days		Min. 8. Da	ate of Birth lonth, Day, Ye	N/A	rthplace (State or Foreign
	Director		Usual Residence of Decedent		8	Yrs.			Se	Pt, 09.	1925 N/	
	ryland		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	he Ma	Director		imore				Dundal	.k			1 ☐ Yes 2X No
	with t	ā	10e. Street and Number 1831 Walnut Ave	enue			10f. Zip Code	21222		"	Citizen of What C	,
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of I	Hispanic Origin	n? (Specify Y	es or No-	Inited St	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinant permittied at once.	þ	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ②☐ N If Yes, Give Year or Dates:	No		fYes, specify Cub 1□ Yes 2□XNo		Риепо нісап,	etc.)	Black, Whi	ite, etc. White
5	"natu	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	1	(Give	lent's Usual Occup kind of work done	during most of	f working	16b	. Kind of Business	s/Industry
12	within iene. then	Completed	Elementary/Secondary (0-12) 8 Years	College (1-4or 5	i+)		00 NOT use retire emaker	d)			Own Hon	ne.
פ	other of her	BeC	17. Father's Name (First, Middle, Last)			11010	Charer	18. Mother's	Name (First	, Middle, Maid		ile
ylai	ould b Menta arked	ToE	Unknown					Unkno	wn			
, Maryland	and 2 shi		19a Informant's Name/Relationship (I Mr. Sammie Gera				g Address (Street Walnut			e Number, Cit k, Mary	ty or Town, State, 121	Zip Code) L222
altimore,	iges 1 t of He : If Item or oth		20a. Method of Disposition		cem	etery, cren	sition (Name of natory or other pla		Date		. Location - City or	
İ	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen		Sacre		<ul> <li>Of Jes</li> <li>Name and Address</li> </ul>	- 1	18/200	6 I	Dundalk,	Maryland
B	Depa Impo any is	9	100/6	9-		D	uda-Ruck 222 Wise	Funera	al Home Dundal	e of Du	ındalk, I vland 2	Inc. 1222
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each lin	10.			ng, such as ca	irdiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		Mok ice of):						
	Examine	-	Sequentially list conditions, if any leading to immediate	b. — Due to (or as a	a consequian	on offe						
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ö,	ficate be executed physicien and is the burial-transit	I Exa	resulting in death) Last	Due to (or as a	a consequen	ce of):						
68760	ficate to physic s the b	edical		d								
Box.	ettending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1∐Live birth 4∐Pregnant at 9∐Unknown	2 Fetel de	ath 3□	Ectopic pregnanc; Other (specify)	<b>/</b>			23d. Date of de Month	livery Day Year
s, P.O	wrequires thet the deben signed by the should be detached	by Ph	Part II. Other significant conditions or		ut not resultin	g in the ur	iderlying cause giv	ren in Part I.	23	Be. Did tobacc	o use contribute to	o the cause of death?
ord	requir		metastat	ic Lun	q C	an	cer		-	Yes	2 □ No 3 □ Pr	robably 4 Unknown
Vital Records,		Completed							-	a. Was an autopsy performed:	prior to death?	utopsy findings available completion of cause of
Z Z	ician: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:			30 DOA   Ott		Death (Chec	ck only one)		
ō	Attending Physician: or death. ector: Atter this certificity the funeral director.	5	27. Manner of Death	28a. Date of Injur	y 281	Outpatien b. Time of	3 DOA 28c. Injur Wor	4 🗆 Nursir		Residence	6 □Other (Spe	ecify)
õ	Attending F death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury		k? Yes 2∐No	1		,	
Division of	after de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home . (Specify)	, farm, stre	eet, factory, office		28f. Lo	cation (Street by or Town, Sta	and Number or Reate)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	rsicien: To the best of iner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tir estigation, in my o	ne, date and p pinion, death o	otace, and du occurred at th	e to the cause ne time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To th To th compl	Me.	29b. Signature and title of certifier				29c. Licens	e number		29d. [	Date signed (Mont	h, Day, Year)
)			Danne Del	P030 1	an		Res	5-00		Sec	tember 1	12, 2006
	5		30. Name and address of person who d					2	25	224		
	Sta	te	31. Date filed (Month, Day, Year)	AVC 32. Registra	r's Signature	Itin	2180	MD	<i>o</i> c	1001		
	Registr		SEF 2 1 2006	Beauty.	D. A.	perli						

			1 - For State Registrar	State of Marylar		tment of H			ne No. 200	5 29910
St. State of the S	Physici /Medi Examir	cal	4a. Facility Name (If not institution, give	Street and number)	RAIAI	lb. City, Town, or	Location of Death	3019	4c. County of Dea	3. Time of Death ath.
20 M	Funeral Director			Medical Cient		If Under 1 Year Months Days	Tows If Under 24 Hrs. Hours Min. 36	8. Date of Birth (Month, Day, Ye	ar) 9. Bi	rthplace (State or Foreign ountry)  MARY Ard
	r 28a-f show	Irector	10a. State 10b. County  MARY/And Bultimon  10e. Street and Number		ty, Town or Loca	tion  VER / E  10f. Zip Code	Α	10g.	Citizen of What C	10d. Inside City Limits 1 □ Yes 2 No ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or itams 23a or 28a-f show apprintly or other traumatic event, the Medical Exacultar result be multiled at ADDE.	by Funeral Director	130 Sipple A	12. Was Decedent Ever in L Armed Forces? 1  Yes 2 No If Yes, Give	If Y	212 s Decedent of Hi es, specify Cuba	36 Ispanic Origin? (Sp n, Mexican, Puerti Specify:	pecify Yes or No- p Rican, etc.)	USA 14. Race - Am Black, Whi	erican Indian, ite, etc.
21215-0036	J within 72 hours piene. r then "natural"	Completed b	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)		(Give kir	nt's Usual Occupa ed of work done of NOT use retired	furing most of wor	king 16b	Kind of Business	
Maryland 2	should be filed nd Mental Hyg marked othe imatic event,	To Be C	17. Father's Name (First, Middle, Last)  Vidoo R HERA  19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street a	PATRAN	TARA  ral Route Number, Cit	chand	Zin Code)
Baltimore, Ma	ages 1 and 2 and 2 and of Health art: If item 27 is y or other trau		VideoR - Patawie Ha 20a. Method of Disposition 1 Depurial 2 Cremation 3 DF	ERAIAI (PARENTS	Place of Dispositi cemetery, cremai	on (Name of tory or other place	Baltime	Date 200.	Location - City or	Town, State
Baltin	permit. P Departme importan any injur,		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	llon	51.0	lame and Address	s of Facility	GOI OSIER Dr.		Md. 21204
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	lable		fent	or respiratory arrest,		Approximate Interval Between Onset and Death 1.5 hours
8760,	4.0	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.						
O. Box 6	ath certif ttending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. d. lf yes, outcome of pregn: 1	af death 3□Ed	etopic pregnancy ther (specify)			23d. Date of de Month	livery Day Year
ords, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the unde	orlying cause give	n in Part I.	23e. Did tobacc		o the cause of death? robably 4 □Unknown
Vital Records,		Be Completed	25. Was case referred to medical				26. Place of Deal	24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
Division of V	ng Phys tter this neral dir	Certification: To E	27. Magner of Death  1. Natural 5 Pending 2 Accident investigation	dospital: 1 X Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing Ho	ome 5 Residence 28d. Describe how in		icify)
DIVI	spitei or hours afte ineral Dir filled in		4 Homicide determined  29a. Certifier Physics	28e. Place of Injury - At h building, etc. (Specification)	(y) owledge, death or	curred at the tim	e, date and place,	28f. Location (Street City or Town, Sta	ate)	e stated
0	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	A. Z. S.L.	_, ~)	29c. License	number 4779	8 J	Date signed (Mont	h, Day, Year)
3	Sta Registr	_	30. Name and address person who con Robert A. (31. Date filed (Month, Day, Year) SEP 2 1 200	TRICKE IN 32 Registrar's Signal	D 70	501 C	Osler T	Drive Tou	wion n	6, 2006

			for State Registrar	State of M	laryland	d / Depa <i>Cei</i>	artment of I	lealth ai <i>Death</i>	nd Mental	Hygie	/ 11	06	29	911
	Physici /Medic		1 Decedent's Name (First, Middle, Las	st)			HARMA	N	2. Date of Month		31, 706	ear	3. Time of	Death M
)	Examir	er	4a. Facility Name (If not institution) give 5. Social Security Number Unk 6. S	kins Ho	SHA	)	4b. City, Town, of	TOLE  If Under 24		of Dieth	4c. County of		(00-1	
	Funeral Director			X M 2□F	ge (In yrs. Ia 82	Yrs.	Months Days	Hours	Min. 8. Date of (Mont) Apr	14, I	924	Coun	lace (State of try)	unk
	Maryland f show	or	10a. State 10b. County		10c. City,	Town or Lo						10	0d. Inside Ci	ity Limits
	with the P	Director	MD  10e. Street and Number			Dal	10f. Zip Code	01.007		10g.	Citizen of Wh		Λ	
	death v	Funeral	209 N. Port Str 11. Marital Status unk	12. Was Decedent Armed Forces	t Ever in U.S	unk 13.	Was Decedent of h	21224 Hispanic Origi		or No-	USA 14. Race -	America		
920	ours after rel', or ite Exemine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates:	No		fYes, specify Cub 1 ☐ Yes 2🌠 No	an, Mexican, Specify:	Puerto Hican, etc	:.)	Specify:	white, e		
1215-0	filed within 72 hours after death with the Maryland Hygiene. the then "neturel", or Iteme 23s or 28s-f show ent, the Medical Examiner must be pullified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	un of working	1k   16k	o. Kind of Busin	ness/Ind	lustry	unk
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Mary	nd 2 should be tall hand Mental to 27 ie marked or r traumatic eve	To	19a. Informant's Name/Relationship (				ng Address (Street					ate, <i>Zip</i>	_	
altimore,	0 0 = =		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 2 Other (Specific	Removal from State	e cer	ace of Dispo	sition (Name of natory or other pla		Date		Location - Ci			
Balti	permit. Pag Department important: eny injury o		21. Signature of Euneral Service Licer ROMALD S.	1/1/100	ector	St Ba	Name and Addre Late Anat altimore,	ess of Facility Omy Bo MD 2	ard 655	W. B	altimor	e S	treet	
	Physician		23a. Part   Enter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each	ed the death.	Do not ent	er the mode of dying	ng, such as ca	ardiac or respirato	ory arrest,		18	Approximat Interval Bet Onset and I	ween
	/Medical Examiner	_	resulting in death)  Sequentially list conditions,	. HYPER	s a conseque	on	77.01.01	1				ά	DYE	PLS
	cuted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. ARRY	thy n	nce or):						/	1434	RS
8760,	cate be executed physicien and the burial-transit	lical	resulting in death) Last	d. End S	tage	1	one d	Struce	five y	SES	SE		ZO YE	ALS
O. Box 6	it the death certific by the attending p tached for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal o	death 3	Ectopic pregnanc Other (specify)	4			23d. Date of Month			Year
rds, P	es tha gned be de	ρ	Part II. Other significant conditions c	ontributing to death I	but not result	ting in the u	nderlying cause giv	ren in Part f.		Did tobac	co use contribu	ute to the		death?
ř	The ete h	Completed								Was an autopsy performed	1? / dea	ith?	osy findings npletion of c	available ause of
	Physician: The this certificete rai director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpati	ient 2514	R/Outpatien	t 3 DOA Ott		of Death (Check of Sing Home 5		o 6 □Othor	/Coociti		
	After		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj. (Month, Da	ury 2	28b. Time of Injury	28c. Injur Wor		28d. Desc		njury occurred	Зреспу	,	
	크를들	Certification:	3 Suicide 6 Could not be determined	286. Place of in	njury - At hom tc. (Specify)	ne, farm, str	eet, factory, office			on (Stree r Town, S	t and Number tate)	or Aural	Route Num	ber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner s	of examination	ledge, death on and/or in	occurred at the til vestigation, in my o	me, date and opinion, death	place, and due to occurred at the t	the caus me, date	e(s) and mann and place, and	er as sta I due to	ited. the cause(s	i)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	- Uya	-	W	29c. Licens	e number	02	29d.	Date signed (#	Month, E	Day, Year)	
			30. Name and address of person who	completed cause of	death (Item 2	23a) (Type,	Print) FE S	f. Ball	11/4028 /1	1/12/1	larl	216	27	d
₹ 3	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	trar's Signatu	ire	de y	A - F	-www.		1: 11 -		~-(-	

06-07065 Ricky Howard Please Type or Print in Black Indelible Ink

2

KICKY Howard		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2006 299
Physicia	an/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year
Medical Exami	ner	4a Facility Name (if not institution, give street and number)  4b City, Town, or Location of Death  4c County of Death
j		St. Agnes Hospital Baltimore W
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY) 9   Birthplace (State or Foreign Foreign Country)   North   Days   Hours   Min.   O   - 1 4 - 1968   Foreign   Country   Ocupativity   Oc
		077-70-407/ 1 M 2 F SS Yrs. Months Days Hours Min. 01-14-1968 Foreign Country) Year Residence of Decedent
w any		10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Ves 2 No
daryland 28a-f show i at once.	Director	10e. Street and Number / 10f. Zip Code 10g. Citizen of What Country?
5-0036 led within 72 hours after death with the Maryland tygiene other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		4702 Vancouver Rd. 21229 USA
ath with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
after de al", or ner mu	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No 1 Yes 2 No specify: Specify:
hours."natur	ted b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
5-0036 led within 72 hours a Hygiene other than "natura the Medical Exami	Completed	11th NA Truck driver Irucking
21215-0036 Uld be filed within 7 Mental Hygiene marked other than r event, the Medica	Be Co	17. Father's Name (First, Middle, Last)  Lester Howard  18. Mother's Name (First, Middle, Maiden Surname)  Minie Pleasson
2121( ould be fill d Mental F s marked tic event, t	TO B	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
nore, MD 2 ages I and 2 shou int of Health and N it: If item 27 is no other traumatic		Minnie Howard - mother 116-37 197 St. St. Albane St. Jamaica, new york 11412  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town State
Baltimore, permit Pages La Department of He Important: If its		1 Buriat 2 Cremation 3 Removal from State Camertery Farming ale. New York
Baltin permit P Departme Importar Injury or		21. Chatur of Funeral Service License 22. Name and Address of Facility 270 Fred #1LTon Pass
ம் ஆக்.≝.≝ Physician	4	238 Pgr. 1. Enter the disease, or complications that caused the death. Do not enter the brode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inter all
/Medical Examiner		Between Onset and Death Death Death
ZAIIIIICI		or condition resulting in death)  Due to (or as a consequence of):
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
, H	Examiner	Chisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		X UNPENDED item#23a.27.perMFg861,11/8/06 TT
'60, cate be o	Medical	item#20b-c,perFH,C860, 10/5/06 TT  IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery
Box 687  death certific  the attending p	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)
Boy he death the att	Physician/	1 Yes 2 No 9 Unknown 9 Unknown
, P.O. res that th signed by be detach	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
	Completed	24a Was an autopsy findings available autopsy prior to completion of cause of
tal Records rian: The law requ certificate has been	ğmö	performed?  1 V Yes 2 No 1 V Yes 2 No
ician:	Be	25. Was case referred to medical examiner?  1 Vas 2 No Hospital 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other.
Sion of Vital Fatending Physician: rdeath ector: After this certifi	12	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred
Sion Attendi r death rector: A	atio	A Natural 5 Pending 1 Yes 2 No 2 Accident Investigation
Divis	Certification:	3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hos 24 h Fur tely		29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
Phylip		O.C.M.E. September 19, 2006
7/	Ì	30. Name and address of person who completed cause of death (Item 23a)  Zobjittleh Ali M.D. Assistant Medical Framines 444 Penn Street Beltimers MD 24264
St	ate	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32 Registrar's Signature
Regist	rar	31. Date filed (Month, Day, Year) 2006 SEP 2 1 2006 Segistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 9:36 AM **Physician** 09 RUTH M. HOLLOWAY-LITTLE 17 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A BALTIMORE CITY GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/28/1954 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** Days Months Hours MARYLAND 1 □ M 2√2 F 214-68-4338 51 **Director** Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County rithen "natural", or Itema 23a or 28e-f show the Medical Examinar must be nutified at ARBUTUS MD BALTIMORE 1 Yes 2 No Direct 10g, Citizen of What Country? 10e Street and Numbe 10f. Zin Code 21227 USA 200 FIRST AVENUE, APT. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK If Yes, Give 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry STATE OF MARYLAND al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASST. HIGHWAY ADMN. 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked of SADIE SHANKS GEORGE HOLLOWAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 505 SANDY CIR., WOODSTOCK, GA 30188 MARSHALL D. CULLINS/SON if item 27 i Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition MD VETERANS CEM. ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If eny injury or once. OWINGS MILLS, MD 9/27/06 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease of condition resulting in death) Endocusch'tis with multi organ failure **Physician** /Medical Examiner Due to (or as a consider ence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit Renel dilicele. The law requires that the death certificate be executed End Stage that initiated events resulting in death) Last Due to (or as a co sequence of) Box 68760. Physician/Medical phys the t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Munknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 2□ No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Innatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 X Natural 5 Pendina 1 Yes 2 No investigation within 24 hours after upware.
To the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 17,2006 Beautra Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Good Samantan Hospital Bahman Saatian 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 and the Registrar

		•	For State Registrar	State of M	<b>f</b> arylan		artment of H rtificate of		and Men		ene 20 (	16	29914
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)						ate of Death	Day Ye	ear	3. Time of Death
	Physici /Medio		Carolee	М.		ckmann			S	ept. 1	7, 2006		7:28 P <sup>M</sup>
Ž.	Examir	er	4a. Fecility Name (If not institution,				4b. City, Town, c				4c. County of		. n da l
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	Funeral Director		215-22-8124	1□ M 2□XF	8		Months Days	Hours	Min. (/	Wonth, Day, 1	1924 M	Count	ace (State or Foreign ry) and
			Usuel Residence of Decedent										
	ehow	_	10a. State 10b. County		10c. Cit	y, Town or Lo						10	d. Inside City Limits
	he M	Director	Md. Anne	Arundel			Glen Bur	nie		10	- Ciri of Mh		
	ours after death with the Marylar rel', or iteme 23a or 28a-f ehow Examiner must be notified at	古	7618 Solley Rd				10f. Zip Code	1060		10	g. Citizen of Wha USA	at Count	ry :
	ne 23	Funeral	11. Marital Status	12. Was Deceden	nt Ever in U.	S. 13.	Was Decedent of H		gin? (Specify	Yes or No-	14. Race -	America	an Indian,
و	or iter		1 ☐ Never Married 2 💢 Marrie	Armed Forces	\$? <b>X</b> No	1			, Puerto Ricar	n, etc.)		White, e	
5-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow ha Madigal Examinar must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2 💢 No	Specify:			Specify:	WI	nite ————
<u>7</u>	72 h natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most	of working	11	6b. Kind of Busin	ess/ind	ustry
2	within then then	m	Elementary/Secondary (0-12)	College (1-4o	r 5+)		nemaker	a)			House	hold	4
7. 0	filed Hygie other	ပိ	17. Father's Name (First, Middle, La	ist)		1101	nemaker	18. Mother	r's Name (Firs	st, Middle, Mi	aiden Sumame)	11010	<u></u>
Maryland	id be ental ked c	To Be	Cecil	Tay	ylor			Fran	nces			Po	zdera
a Z	s 1 and 2 should f Health and Men fram 27 ie marke other traumatic	Н	19a. Informant's Name/Relationshi	(Type, Print)		19b. Maili	ng Address (Street	and Numbe	r or Rurai Rou	ute Number,	City or Town, Sta	te, Zip	Code)
	and 2 alth a 27 is		Casper Hackmann	(Spouse)		7618	Solley R	d. Gle	en Burr	nie, Mo	d. 21060		
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State		emetery, crei	sition (Name of matory or other pla		Date		Oc. Location - Cit		
Ĕ	Pages ment of ant: if it		4 ☐ Donation 5 ☐ Other (Spe	cify)	°∣Md.		ans Cem.		9/22/06		rownsvil		
<u>a</u>	permit. Pag Depertment Important: i eny injury o		21. Signature of Furieral Service Li	ens e		2	2. Name and Addre	ss of Facility	, Stall	ings	unerai	Home	er'A
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly one cause of each	line.	i. Do not en	er the mode of dyli	ng, such as o	cardiac or res	piratory arres	it,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a			Mosur	en u	may				
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gox	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetel	death 3	Ectopic pregnancy Other (specify)	,			23d. Date of Month		y Day Year
o.	0 0	ysid	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown		Julii 3 L							
 J	law requires that the as been signed by th 2 should be detache	by P	Part II. Dther significant condition	s contributing to death	but not resi	ulting in the u	nderlying cause giv	en in Part I.	:	23e. Did toba	cco use contribu	ite to the	cause of death?
ğ	w require been sig should b	ed E		re	men	lien				1 🗆 Yes	2 No 3	] Proba	ably 4 Minknown
Vital Records,	law re	plet			Au	Sino	2			24a. Was an autopsy	24b. Wer	e autop	sy findings available
ř	The ate h page	Completed				<i></i>			1	performe	No 1	th? Yes	pletion of cause of
<u>=</u>	Physician: The law this certificate has b ral director, page 2 s	Be (	25. Was case referred to medical examiner?	-		/			of Death (Chi	eck only one			
5	Physic this c	ို	1 ☐ Yes 2 Ø No			R/Outpatier		4   1901			ce 6 Other (	Specify,	)
	ling After lune	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time o Injury	Woo	yat rk? Yes 2.⊟1		Describe how	r injury occurred		
DIVISION	tend death tor: the	ficat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be One Diese of I	niury - At ho	me, farm, sti	eet, factory, office	163 2 1		ocation (Stre	et and Number o	or Rural	Route Number
$\stackrel{>}{=}$	이 분들 드	Certification;	4 Homicide determin	building,	etc. (Specify	()	oor, ractory, chiloc			City or Town,			, route rrampor,
	To the Hospital or Ai within 24 hours after of To the Funeral Direction places on pletely filled in by		29a. Certifier 1 Cartifying	Physician: To the bes	st of my kno	wledge, deat	h occurred at the ti	me, date and	d place, and d	lue to the cau	se(s) and manne	er as sta	ited.
	he Ho in 24 he Fu pletel	edical	ons)	taminer: On the basis and manner s	ot examina stated.	tion and/or in	vestigation, in my o	pinion, deat	h occurred at	the time, dat	e and place, and	due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	VIO 9	Ru	2	29c. Licens	number	221 -	290	d. Date signed (A	Aonth, D	Day, Year)
•			<b>)</b>	*U		-2	<u> </u>	97/	700		~(11)	010	6
	3	59	(PAN)CED	GARLY,	M) (Item	23a) (Type, 420	29c. Licens Print) M M7	. 120	, PAS	12(1E	A, my	2	1122_
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			1 - For State Registrar	State of Mary		oartmen e <i>rtificate</i>			ınd M		jiene	006	29915
	Physic		1. Decedent's Name (First, Middle, Last,	)			21	auto	C	2. Date of Dea Month	th Day	Year	3. Time of Death
1	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	791	4b. City,	Town, or	Location of	f Death	SEPTEMI		ty of Death	N/A
	Funeral Director		5. Social Security Number 6. Security Number 216-44-1852	7. Age <i>(In</i> M 2□F 60	yrs. last birthda Yrs.	y) If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth	45 (45)	9. Birthp Cour	lace (State or Foreign try) MD
	Maryland 9-f ahow	tor	10a. State 10b. County  MD BALTIN		c. City, Town or	Location THERVII	LLE		_			1	0d. Inside City Limits
	ith with the 23a or 28 ust by not	al Director	10e. Street and Number 660 STRAFFAN DRIN	/E #102		10f. Zip	Code	21093	3		l0g. Citizen of	What Coun	try? USA
9036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28e-f ahow f.a Madical Examinar Laus be netitied at	d by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	in U.S. 13	B. Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto I	ocify Yes or No- Rican, etc.)	14. Ra Bla Speci	ace - Americ ack, White, ify:	
21215-0036	be filed within 72 hours tal Hygiene. d other then "natural", event, Ire M. dicel Exe	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed)	(Giv	edent's Usua ve kind of wor DO NOT us	rk done d se retired,	lurina most	of workii	ng	16b. Kind of 8		dustry
Maryland	2 should be filed vand Mental Hygie Is marked other is sumatic event, III	To Be	17. Father's Name (First, Middle, Last) DAVID			ITOF		FRAN	NCES	(First, Middle,			ABRAMS
	1 and Health em 27 ther ti		19a. Informant's Name/Relationship (Ty CAROL HAWTOF / W] 20a. Method of Disposition	[FE	660 Ob. Place of Disp	STRAFF	AN [	DRIVE	#102	I Route Number 2 - LUTI		.E, MD	21093
Baltimore,	nit. Page: artment o ortant: If injury or is.		1	Į Ł	BETH EL	MEMOR] 22. Name an	[AL F	PARK 9		/2006	RANDA	ALLST0	WN, MD
Ä	Deprinciple of the control of the co		23a. Part1. Enter the disease, or complishood, or heart failure. List only or	lications that caused the		8900 F	REIST	ΓERST	JWN I	L LEVINS ROAD - r respiratory arr	PIKESVI		MD 21208 Approximate
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)	<b>N</b> 1	nsequence of):	hyp	ert	eu s	ion				Interval Between Onset and Death 2 WELKS
68760,	icate be executed physicien and street transit	dicai Examiner	Cause (Disease of right) that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):								
O. Box	at the death certific by the attending p tached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ i 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pre						ate of delive onth	ry Day Year
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of Vital Records,	The law ate has b page 2 s	Completed								24a. Was a autops perform	y	prior to con death?	osy findings available apletion of cause of
Vit.	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Inpatient	2 ☐ ER/Outpatie	ent 3□ DO	A Othe	_		Check only on		h (C	
	ding After fune		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time		8c. Injury Work		2	8d. Describe ho			)
Division	2 to 15 co	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, s	treet, factory,	, office		2	8f. Location (SI City or Town		ber or Rurai	Route Number,
	ne Hospitel	edicai	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, dea mination and/or i	ath occurred a investigation,	at the time in my op	e, date and inion, death	place, a	nd due to the cond at the time, d	ause(s) and m ate and place,	anner as sta	ated. the cause(s)
	To the I within 2 To the I complet	¥	29b. Signature and title of certifier	re Posse	HO		. License		0 070		9d. Date signe		
•	13		30. Name and address of person who co	impleted cause of death	(Item 23a) (Type	Print)	21	11:00-	21	1/10.11	sold .	1/50.	7
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 1 2006	32. Registrar's S	ignature	SI.	IJ₩.	MANUE	KC)	144144 18	TIVER O	(1,00	

State of Maryland / Department of Health and Mental Hygiene, 1 - StateAmend item#7, perFH, C859, 9/21/06 TT Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SEPT. 2006 9:35 A<sup>M</sup> 14, TOMAS SILVESTRE IGNOLFI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY 5526 ARPINA RD. ROCKVILLE - APT. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days 1XM 2□ F Months Hours Min. 55 Director 11/30/1950 ARGÉNTINA N/A Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show itam 27 la marked othar than "netural", or Itams 23a or 28a-f shov other traumatic evant, It e McClcal Examinar must be notified at 1 XYes 2 No Director MONTGOMERY ROCKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT. 20852 ARGENTINA #7 death by Funeral 5526 ARPINA RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2□ No Specify: ARGENTINIAN Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. Ih and Mental Hygiene. 7 Is marked othar than "ne Elementary/Secondary (0-12) College (1-4or 5+) TEACHER/RESTAURANT CHEF 12TH17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ SILVESTRE IGNOLFI TERESA SRIZZO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Ia m any injury or other traum <u>once.</u> WILLIAM ZAMBRANO 2311 UNIVERSITY BLVD., WHEATON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 09/28/06 SAN MONICA SAN ANTONIA, DEPADVA 21. Signature of Funeral Service Lice 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each in Immediate Cause (Final disease or condition resulting in death) Physician Htherosclerotic cardiovascular years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. ☐ Yes 2☐ No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Xes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manyfer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Ciractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as success.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medica (Check only the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23 (Type, Print) Pike, G-100, 31. Date filed (Month, De State Registrar

		1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artmei <i>rtifica</i>	nt of He te of D	ealth and leath		neg. No	2006	29917	
Physic /Medi		1. Decedent's Name (First, Middle, Las Baby Girl	ones					2. Date of Dat	, Da	26 200	3. Time of Death 23:10. f M	
) Examii	ner	4a. Facility Name (If hot institution, give	IVICW	to a black to 3		Salti	ocation of Dear MOTC If Under 24 Hrs	th J	40	Sounty of Dea Paltimb	re City	
Funeral Director		5. Social Security Number  6. Social Security Number  10  10  11  11  12  13  14  15  16  16  16  16  16  16  16  16  16	fx 7. Age (In yrs. ☐ M 2 万 F	Yrs.	Months		Hours Min 40		Day, Year)	06 Ma	thplace (Statefor Foreign buntry) ryland	
Maryland -f ehow	tor	10a. State 10b. County		ty. Town or Lo							10d. Inside City Limits	
with the 3a or 28e-	I Director	10e. Street and Number 212 S. Robinson		JOSE C INC		p Code	21224		10g. Ci	tizen of What Co	-	
ING 21215-UU36  be filed within 72 hours after death with the Maryland tlat Hygiene. d other than "natural", or Iteme 23a or 28e-1 show event. I've Medical Examinat must be notified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 \( \text{Yes}		panic Origin? (9 Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: b1	e, etc.	
27275-0036 d within 72 hours af giene. r then "natural", or	Completed I	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	kind of w	ual Occupati ork done du use retired)	ion ring most of wa	rking	16b. K	(ind of Business	/Industry	
filed with Hygiene.	Be Co	none 17. Father's Name (First, Middle, Last)	none	no	one	1	8. Mother's Na	me (First, Midd	non le, Maider			
	To B	Kenneth Pettiwa	У					eysha N				
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		19a. Informant's Name/Relationship (7)  Johns Hopkins Ba						ural Route Num Baltimo		or Town, State, 2		
Sattimore, IV Deprint. Pages 1 and Department of Health mportant: If item 27 any injury or other tr anse.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 \$\infty\$ Other (Specify,	20b. I	Place of Dispo cemetery, cren	sition (Na	me of		Date	-	ocation - City or		
Barrimory permit. Pages Department of temportant: if ite any injury or of		21. Signature of Funeral Service Licens					ny Boar D 2120		. Bal	Ltimore	Street	
Physician		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	th. Do not ent	er the mo	de of dying,	such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death	
parton of the property of the principle of the physician and so the burial-transit of the principle of the p	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consector)  Due to (or as a consector)  Due to (or as a consector)  d	quence of):		h	ipture	of Me	mbr	ancs	40 min.	
ecords, P.O. BOX 68/ law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medi	JF FEMALE: 23b. Was decedent pregnant in the past 12 rgonths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic p					23d. Date of de Month	ivery Day Year	
ecords, F. law requires that las been signed by	ρ	Part II Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying	cause given	in Part I,		tobacco		the cause of death?	
The The page	Completed							24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were au prior to death?	utopsy findings available completion of cause of	
r VITAL I yeicien: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpation	* 3□ D	Other		ath Check only		e Mother (Can	0.4.1	
On O		27. Manner of Death  1 Natural  2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day Year)	2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sur) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No					спу)			
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:									n (Street and Number or Rural Route Number, Томп, State)		
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To the within 2 To the complete	Me	29b. Signature and title of certifier			29	D5	9302		29d. Da	ite signed (Mont	h, Day, Year)	
314.		30. Name and address of person who c	ompleted cause of death (Iter H)MC 494)	n 23a) (Type, + QS+CV)	Print) Av			orc. M	10 2	21224	-	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 1 2	32. Registrar's Sign	iture.	2845	J.F.	~ " !   ! ! ! ! !	01 ' '				

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Physicia	in/	Registrar  1. Decedent's Name (First,								of Death		3. Time	of Death
lical Examir			Iris Jos		<u></u> _					b Day Jst 29, 20			0 hrs
J		<ol> <li>Facility Name (if not ins 4241 Hill Lane</li> </ol>	titution, give street	and number)		41	b. City, Town Crisfield	or Location o	f Death		<ul><li>c. County of De</li><li>Somerset</li></ul>	ath	
Funeral	4	5. Social Security Numbet	nk 6. Sex	7. Age	(In yrs. last t	oirthday)	If Under 1	rear If Unde	r 24Hrs. 8. Dat		1/DD/YYYY) 9.	Birthplace (	State on ink
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23s or 28s-f sho injury or other tranmatie event, the Medical Examiner must be notified at once.		11. Marital Status		as Decedent I	Ever in U.S.	13. Was	Decedent of		in? ( Specify Ye	s or No-	USA 14. Race - An		ın, Black,
leath v	Funeral		X Married Ar	med Forces? Yes 2	X No	If Ye	s, specify Cu	ban, Mexican,	Puerto Rican, e	etc.)	White, etc	<b>:</b> .	
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MD and 2 sho salth and 2 sho sem 2 is		O.C.M.E.  20a. Method of Disposition			20h Plac		enn St		altimor Date		21201 Location - City	or Town S	rate
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sion of Vital Reco	To Be	examiner? 1 ✓ Yes 2 N	Hospital  28  Pending Investigation	a. Date of Inju (Month, Day,Y	ry 28	Bb. Time of Ir	njury 28c.	Yes 2	? 28d. D				
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ledica amine		4a. Facility Name (If not institution,	4-13	iber)	4b. City, Town	, or Location of D			County of Death	14.20
		Northwest Hos				allstov		Ва	ltimore	
eral tor		5. Social Security Number 200 89 8467	6. Sex 1 M 2 □ F	7. Age (In yrs. last bir 82	thday) If Under 1 Year Yrs. Months Day		din. (Month, D	ay, Year)	9. Birthplac Country 124 Ukrair	e (State or Foreig
		Usual Residence of Decedent					Jan. 1	6, 19	24 UKrair	ne
	_	10a. State 10b. County		10c. City, Town	n or Location				10d.	. Inside City Limits 1 ☐ Yes 2X No
	Director	MD Baltimo	ore	Reiste	rstown 10f. Zip Code			10a Citia	en of What Country	
		5 Surry Court			2113				aine	
	Funerai	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. Was Decedent o	f Hispanic Origin	? (Specify Yes or Nuerto Rican, etc.)		4. Race - American Black, White, etc	
	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes	2√D No	1 ☐ Yes 2 ☒XN		derio i licari, etc.,	ع	Specify:	<i>.</i>
	ed b	15. Decedent	Year or Da		Decedent's Usual Occ	unation	white		whit	
	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-		(Give kind of work dor life. DO NOT use reti	ne during most of	working	100.10	a or basinessymous	sti y
	Com	8			chnician			Han	dyman Com	npany
	Be	17. Father's Name (First, Middle, L	ast)				Name (First, Middle	, Maiden S	Surname)	
- 1	၉	Matus Knobel  19a. Informant's Name/Relationsh	in (Type Print)	10h	. Mailing Address (Stre		Terrefh	ar Cituar	Taura Chata Ta Ca	
. 1		Inna Yurkozsky			Surry Cou					5 <del>00</del> )
		20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other p		Date		ation - City or Town	, State
		1 ☐ Burial ZXCremation 4 ☐ Donation 5 ☐ Other (Sp		tate	Crematory	· I	p. 21. 06	Balt:	imore, MD	)
once.		21. Signature of Funeral Service L	act so	1	22 Name and Add Crematic 299 Fred	ress of Facility			Inc. MD 21228	
			Due to (d	or as a consequence of	9117 of):					
	ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consequence of	of care	W. 14	VENRL	TIO	N.	
	lical Examin	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (c) c. Due to (c) d.  23c. ff yes, outc	or as a consequence of as a consequence of as a consequence of as a consequence of the consequence of pregnancy the 2 Fetal death and at time of death	of):  of):  of):	ncy	VENRE		3d. Date of delivery Month Da	ıy Year
	Physician/Medical Examin	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition	b. Due to (c) c. Due to (c) d.  23c. ff yes, outc 1	or as a consequence of as a consequence of or as a consequence of or as a consequence of the consequence of	of):  3 Ectopic pregnar 5 Other (specify)	icy	23e. Did	23	3d. Date of delivery Month Da e contribute to the c	cause of death?
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amend 20bc per F.Hplease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	of Maryla		artment of H		Mental Hyg	iene g. No. 20	06	29920
			Decedent's Name (First, Middle	, Last)					2. Date of Deat	h		3. Time of Death
	Physici /Medio		Heavenly	Kel	lv				Month 09	0 7	Yeer 2006	10:30AM
	Examir		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Dea	ith	4c. County		10.30
			Greater Balt:	more Me	dical	Cent	Towso	n		Balt	imor	e County
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year	if Under 24 Hr	s. 8. Date of Birth		9. Birthpl	ace (State or Foreign
	Director		none	1□M 2 <b>X</b> F		Yrs.	Months Days	Hours Mir 3 46	0. (Month, Day,	2006	M D	try)
	D .		Usual Residence of Decedent							2,000		
	how	_	10a. State 10b. County		10c. C	City, Town or Lo	ocation				10	Od. Inside City Limits
	B Ma	cto	MD		Ro	sedale	<u> </u>					1 ☐ Yes 2 ☑ No
	th th	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Count	try?
	15 wi		5437 King A	rthur Cá	rcle		21237					
	dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in			lispanic Origin? (	Specify Yes or No-		e - America	
9	or Ite		1 Never Married 2 Marr	ed 1 Tes If Yes, Gi	2 No		1 ☐ Yes 2 ☐ No		no nican, etc.)		ck, White, e	etc.
93	ral',	1 by	3 Widowed 4 Divorced	Year or E	Dates:		ILL Tes ZUZINO	Specify:		Specify	Bla	ack
5-0	4 within 72 hours after death with the Maryland jiene. 1 than "natural", or Items 23a or 28a-f show The Medical Examinating the molified at	Completed	15. Deceden (Specify only highes	's Education		16a. Dece	dent's Usual Occup	ation during most of w	orkina	6b. Kind of B	usiness/Ind	ustry
2	within ene. than "	npie	Elementary/Secondary (0-12)	College (		life.	DO NOT use retired	1)		/		
2	filed with Hygiene. Ithar thai	Ç	0	(	)		Infan	+		Inte	ant	
p	m - 0 2	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ime (First, Middle, M	faiden Surnan	ne)	
/la	should be and Menta markad umatic ev	ည	Lamont	Kelly				Shawai	n K	ellv		
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Street		Bural Route Number,		State, Zip	Code)
	1 and 2 Health em 27 i		G.B.M.C. 8971	402067		6701	NUM	145 5	T TOWSO	n m	Zi	204.
ī.	es 1 a of Hes of Hes fitem rothe		20a. Method of Disposition		- 1	Place of Dispo	sition (Name of natory or other place	ca)	The state of the s	Oc. Location -	City or Tov	vn, State
Ë	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S)		State Gr	een Mou	mt Crema	tory 9	/12/06	<b>Baltin</b>	ore.	MD.
altimore,			21. Signature of Funeral Service			22	. Name and Addre	ss of Facility	11 86.	V5 Co.	o, .	
ä	permit. Departifmports any Inj		1 Collect	Pario	1	H	KNCY W.	DEN S	105 10		211	11
			23a. Part1. Enter the disease, or	complications that	caused the dea	ath. Do not ent	er the mode of dvin	ng, such as cardia	c or respiratory arre	st.		Approximate
	Pnysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse		elivery					Onset and Death
	cate be executed physician and the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conse	guence of):						
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	e as	0	IF FEMALE:							1		
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۵.	res that igned by be deta		Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use cont	ribute to the	cause of death?
Records,	The law requires tte has been sign page 2 should be	d by					none		1 ☐ Yes	2 500	3 Proba	bly 4 Unknown
Ö	v requii been s should	Completed							04-146	24.	All .	
že	elav has	mp							24a. Was an autopsy perform		were autop: prior to com death?	sy findings available pletion of cause of
		Ö							1 ☐ Yes 🎾		Yes 2	2 □ No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	100 000					ath Check onl one			
of		2	1 ☐ Yes 2 7 No			ER/Outpatien		4   Nursing	Home 5 Resider	nce 6 Oth	er (Specify)	
		ü.	27. Manner of Death 1 SHatural 5 ☐ Pending	28a. Dite (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe how	v injury occurr	ed	
000	Attending r death. sctor: After by the fune	atl	2 Accident investig	ation			M 1 🗆	Yes 2 □ No				
	I or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Hornicide determ	ned Zoe. Place	of Injury - At h	nome, farm, str	eet, factory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,
	tal or s afte at Dir	Cer				,						
	To the Hospital or Attenwithin 24 hours after deatl To tha Funeral Director: completely filled in by the	edical	29a. Certifier Certifyin (Check only one)	<b>Physician:</b> To the Examiner: On the band man	best of my kn asis of examin ner stated.	owledge, death ation and/or in	occurred at the timestigation, in my of	ne, date and plac pinion, death occ	e, and due to the car urred at the time, dat	use(s) and ma te and place, a	nner as sta and due to t	ted. he cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	1			29c. License	a number	29	d. Date signed	(Month, D	ay, Year)
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		1				- 02c\ /T		58986	7	. 7 - C	6	
			30. Name and address of person		·			+ 17 Dl +7	d.; Balt	imoro	. MD	21244
	-01		Christine H. 31. Date filed (Month, Day, Year)		oo, MD legistrar's Sign	aturo		rra DIA	u., Dall	THOLE	7 110	
	Sta Registr		SEP 2 1	2006	Salar Sagn	S. A.	mel					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death KRECHER **Physician** Month Year RUBERT 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1007 Twin View Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F 80 219-10-6522 Director Jan.18,1926 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "naturel", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Directo MD Anne Arundel Glen Burnie 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 1007 Twin View 21060 U.S.A. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Electrician Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be .. Pages 1 and 2 should be fit thent of Health and Mental H tant: If item 27 is marked off Andrew Krecher Edith Discus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 1007 Twin View Glen Burnie, Maryland 21060 Mrs. Geraldine Olivia Krecher/ or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 22, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park 2006 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. MO/357 1 Second Avenue SW Glen Burnie, MD 21061 laneur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) the way **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a contequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. ed by the attending physician detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 31 No after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral ( completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWA MICHAEL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 1 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death 06-07093 Kevin George Konsowski 2006 29922

		Registrar			еппса	e oi	Dealli				R	eg. No	- 0 0	0 2332
Physicia ledical Exami		1. Decedent's Name (First, Midd Kevin George K	onsowski								Date of Dea Month Septembe	er 19, 2006	ear	3. Time of Death 1915 hrs
		4a. Facility Name (if not institution 1216 Hasting Hunt W		number)		4	b. City, Tov Severn		ocation of	Death		4c. County Anne A		
Funeral Director		5. Social Security Number 220-70-0271	6. Sex	7. Age (In yr	s. last birtho	lay) Yrs.	If Under	1 Year Days	If Under		8. Date of Bi	,	Foreig	thplace (State or in untry) MD
		Usual Residence of Decedent	1	1			1			LI				
nd ihow any ce.	اً	MD Anne	Arundel	10c. C	Seve		on							10d Inside City Limits  1 Yes 2 X No
te Maryland or 28a-f show fied at once.	Director	10e. Street and Number	IIt U				10f. Zip Ci				1	0g. Citizen of V		ntry?
with the M is 23a or 2 e notified		1216 Hasting  11. Marital Status		ecedent Ever in	u.S.	13 Was			anic Origin	n? (Spec	cify Yes or No	U.S.A		can Indian, Black,
b, MD 21215-0036 and 2 should be fifted within 72 hours after death with the Maryland teath and Memial Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	y Funeral	1 Never Married 2 X N 3 Widowed 4 Di	1 Yes				es, specify ( Yes 2 X			uerto Ri	ican, etc.)	Wh Specify	ite, etc. wh	nite
2 hours a "natura I Examir	eted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)		ade completed			s Usual Oc est of working					16b. Kind of E	usiness/li	ndustry
215-0036 be filed within 72 ntal Hygiene rked other than "	Completed		2		HV	'AC	Techn					Self		_oyed
e, MD 21215-003 I and 2 should be filed within Health and Mental Hygiene item 27 is marked other it r traumatic event, the Med	Be Co	17. Father's Name (First, Middle Stephen Konsow						18			First, Middle, I Reinke	Maiden Surnam	e)	
and 2 should be filealth and Mental tem 27 is marked traumatic event,	ToB	19a. Informant's Name/Relation			19b.	Mailing	Address	(Street				≐ nber, City or To	wn, State	, Zip Code)
MD nd 2 sho alth and m 27 is aumati		Mrs. Patricia	Konsowski		b. Place of							ern, MD		
		20a. Method of Disposition  1 XBurial 2 Crematio  4 Donation 5 Other S		from State	cremator Cedar	y or oth	er place)				Date 26 / 2006	Brool	,	
Baltimore permit. Pages   Department of F Important: If i	Ì	21. Signature of Funeral Service	e Licensee	/		22. Na	ame and Ad	ddress o	of Facility	Sin	gletor	Funera	al Ho	ome, PA
Physician		23a. Paul I. Enter the disease, o failure. List only one cause		caused the de	1357 ath. Do not									Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	e a. Head i	njuries a consequenc	a of\:									Death
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ecuted and transit			d											
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ox 68760, sath certificate be attending physici.		23b. Was decedent pregnant in t past 12 months?	the 1 Live	s, outcome of p birth gnant at time o	2[		al death	3	Ectopic p	pregnanc	;y	23d Date of Month		Day Year
P.O. Box 68 that the death cert med by the attendir	hysici		nknown 9 Unk	nown			ner (Specify							
, P.O.	by P	Part II. Other significant condi	itions contributing	to death but no	ot resulting i	n the ur	nderlying ca	ause giv	en in Part	l.	23e. Did to			the cause of death?
Records, The law require ficate has been si	Completed										24a. Was autop		prior to c	topsy findings available completion of cause of
Reco The law icate has	T O										perfo 1 <b>Y</b> Yes	rmed? 2 No	death? 1 ✔ Ye	es 2 No
Tital Recisions: The secrificate irector, page	Be	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	ER/Out	natient			of Death (Co		ly one) Home 5	Residence 6	✓ Other	Scana
of Ving Phys After this	٦: ح	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b. Ti				at Work?	<u>-</u> _		how injury occu		. Scene
sion trendii death ctor: A	atio		estigation Fnd	9/19/200					s 2 X	2		fell stri		
Division of Vital pital or Attending Physician ours after death erral Director: After this certifiled in by the funeral director	Certification:		uld not be ermined (Specif	ace of Injury - A		n, stree	t, factory, o	ffice bu	ilding, etc.	28	8f Location ( or Town, S evern,	Street and Num itate) 1216 F	per or Rui aslin	ral Route Number, City g Hunt Way
Division of Vital Records, P.O. Box 68760, within 24 hours after death  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Ameral director, page 2 should be detached for use as the burial - trans	Medical C	29a. Certifier 1 Certifying F	Physician: To the b aminer: On the basi and manner	s of examination	_									
E 3 E 8	Me	29b. Signature and title of certif					- 1		number					nth, Day, Year)
		Theodor	M. Y.	135	num	10.	(	D.C.M	I.E.			Septembe	er 20, 20	J06
7		<ol> <li>Name and address of perso Theodore M. King, Jr</li> </ol>		use of death (I tant Medica	<sub>tem 23a)</sub> Il Examir	ier	111 Pen	n Stre	et, Balti	imore,	MD 2120	1		
S Regis	tate trar	31. Date filed (Month, Day, Year, SEP 2	1 2006 32	R strar's Sigi	nature	So	uli)							

State of Maryland / Department of Health and Mental Hygiene 2006 29923 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:50P<sup>M</sup> Alice Μ. Kauffman September 19,2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care Cherrywood Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sep. 22,1915 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M XXXF 219-18-2185 Yrs. 90 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 Yes XXNo MD Baltimore Pikesville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8824 Orchard Rd. 21208 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: þ X3X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 ie marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Unknown Emma Mae Kaylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) Lois M. Sullivan / Niece 263 Pittston Circle; Owings Mills, MD 21117 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place Evergreen Mem. XX Burial 2 Cremation 3 Removal from State 9/23/06 4 ☐ Donation 5/☐ Other (Specify) Finksburg, MD Gardens 21. Signature of Juneral Service Licenses 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. once ichan 11605 Reisterstown Rd. Owings Mills,MD 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itiated events resulting in death) Last Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf dea 23d. Date of defivery 23b. Was decedent pregnant 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? page 212 No this certificate 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: ector, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospitaf: 1 Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZNo ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 Natural М 1 TYes 2 TNo within 24 hours arrestors. To the Funeral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide t 🔂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND Wan 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylan		ent of Health an ate of Death		ene2006	29924
	Physici /Medic		1. Decedent's Name (First, Middle, La: ESSe Wi	Leak J	r.		2. Date of Death Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, pixed on Secours 1)  5. Social Security Number 6. S	e street and number)  SPITAL  ex 7. Age (In yrs. i	B	City, Town, or Location of D CUT MOY Inder 1 Year   If Under 24	Hrs. & Data of Birth	4c. County of Death  Baltin  9. Birth	A 1
	Funeral Director			XM 20F 55	Yrs. Mont		Min. Jan. 11,	1951 M	aryland
	e Marylan la-f show	ctor	10a. State 10b. County	10c. City	Nown or Location	nore			10d. Inside City Limits 1 XYes 2 □ No
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It amarked other then "neturel", or Iteme 23e or 28e-f show treumatic event, the Medical Exam har must be notified at	Funeral Director	10e. Street and Number 255 N. M.  11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	6	Zip Code  2/23  eccedent of Hispanic Origin specify Cuban, Mexican, F		g. Citizen of What Co	nican Indian,
9600	hours after ural', or Ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	1 □ Ye	s 2 No Specify:		Black, White	lack
21215-0036	filed within 72 h Hygiene. Wher then "national, the Medica	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's l (Give kind of life. DO NO	Jsual Occupation ( work done during most of the state of	t working	6b. Kind of Business/	Industry
Maryland	nould be filed I Mental Hygid narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last,	Leak Sr.	T-05 M. F-1 Add	Ma	Name (First, Middle, M	en	E- O-da
	1 and Heal		19a. Informan's Name/Relationship ( 20a. Method of Disposition	Smith 20b. P	3525 lace of Disposition (emetery, crematory)	Francis (Name of or other place)	St. 1st Floor		Md. 21217
Baltimore	permit. Pages Department of Important: If it any injury or o		1 MBurial 2 Cremation 3  4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	y) GO	irrison		26/2006 (	Dwings N	Mills, Md. P.A.
	Physician		23a. Part Enter the disease, or com shock, or heart filter. List only Immediae Cause (Final	one cause on each line.		mode of dying, such as ca	rdiac or respiratory arre	ito Md.	Approximate Interval Between Onset and Death
一 明	/Medical Examiner		disease or condition resulting in death)	a. Due to or asia consequ	vopath	v			lyr.
<b>√</b>	te be executed ysicien and se burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence o	S A L	ery Disa	ease ney Dis		2001/540
68760	ificate be e g physicien as the buria		(	ESRD	Chron	nic Kid	ney Dis	euse	1999(byr
O. Box	The law requires thet the death certificate be executed tite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□Ectop	ic pregnancy (specify)	- Tra-	23d. Date of deli Month	very Day Year
rds, P.	w requires thet the been signed by should be detact	þ	Part II. Other significant conditions of	contributing to death but not resu	ulting in the underlyi	ng cause given in Part I.		acco use contribute to	the cause of death?
Vital Records,		Completed	Lang m	ass.			24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Linguital.			Death (Check only one	)	
of	유 유 등	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2   28a. Date of Injury	ER/Outpatient 3 28b. Time of		ng Home 5 Resider		cify)
L C	ding f h. After funer	lon	1XNatural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
Division	or Attendifter death	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	1	ome, farm, street, fac	1		eet and Number or Ru State)	ral Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medicai	(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occur tion and/or investiga	tion, in my opinion, death	occurred at the time, da	te and place, and due	to the cause(s)
	To To		29b. Signature and title of certifier	()		29c. License number		d. Date signed (Month	
			30. Name and address of person who CHUKWUEMEKA 31. Date filed (Month, Day, Year)	completed cause of death (Item	23a) (Type, Print)	Baltimaro	St Rait	mave M	D 21223
	Sta Regist	110	31. Date filed (Month, Day, Year)		ture.	k)	-1, 5-0001	1 - 1°1.	<i>y</i> = <i>y</i>

		4	For Stata Ragistrar	Amend I	State o	of Marylar per fh,	nd / Depa <b>3864 <i>02</i></b>	rtment o	f Health beath	and Me	ental Hyg	giene ( Reg. No.	2006	29925
	Physicia	an	1. Decedent's Name (I		(1)		; 0	PPV		2	2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If no		street and nu	mher)	LA	RRY 40 City Tow	n, or Location	of Death	09	19	DO DO Deat	2:33AM
7	Examin	er	University	-	,		Center	Bal	t mon	e Cit	ty	70. 0	N/A	
	Funeral Director		5. Social Security Num 219-30-05	ber 6. S		7. Age (In yrs.	~	If Under 1 Ye Months Da		Min. 0	B. Date of Birtl (Month, Day 5/22/1	<sup>h</sup> , <sub>Year)</sub> <b>919</b>	9. Birt Co	thplace (State or Foreign buntary)
	yland		Usual Residence of De 10a. State	Ob. County		_	ty, Town or Loc							10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f ehow ir must be notified at	Director	MD			B	altim	<i>ore</i>						1 Yes 2 □ No
	with th	Dire	10e. Street and Number		1.00			10f. Zip Cod	10 10			10g. Citiza	en of Whai Co	ountry?
	death ms 23	Funeral	1313 Hrd 11. Marital Status	ayle F	12. Was Dec	edeni Ever in U	J.S. 13. V	Vas Decedent	of Hispanic Or	rigin? (Spec	ify Yes or No-	14	4. Race - Ame	
9	hours after tural', or ite		1 Never Married		Armed Fo 1 ☐ Yes If Yes, Gi	2 No		Yes, specify (	Cuban, Mexica No <i>Specify</i> :		can, etc.)		Black, While	e, etc.
8	hours tural',	ed by	3 Widowed 4 [	Divorced 	Year or E	Dates:		ent's Usual Oc					d of Business/	ack
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene.  d other then "natural", or items 23s or 28s-f show event, its Medical Exacting must be political.	Completed	(Specify Elementary/Second	only highest gra	de completed) College (		(Give I	cind of work do OO NOT use re	one during mos	st of working	,	100. 1	-	dddiy
	led wil lygien her tha		8+4				6	item	18. Noth	r	(	lity	of Ba	ltimore
and	uid be fii Mental H irked otl	o Be	17. Father's Name (Fir	St, Middle, Last)					18. Moth	iers Name (	First, Middle,	Maider	iumame)	
Maryland	s 1 and 2 should f Health and Men item 27 ie marke other traumatic	ဥ	19a. Informant's Name	a/Relationship (	Type, Print)		19b. Mailin	g Address (Str				r, City or	Town, State, 2	Zip Code)
-	and 2 lealth a m 27 is		William	Larry	150	20	515 Place of Dispos	Gwyr	mrale	e Ro	1.Pil	45V	We M	D 21208
Baltimore	00		20a. Method of Dispos	Cremation 3		State 20b.			f place)		te	20c. Loc	ation - City or	Town, State
Itim	그 든 뿐 글		4 ☐ Donation 5 21. Signature of Fuge				Ling	Park Name and Ad	Idrass of Facili	9/23/	06 1	pal+	more	mo
Ba	Depa Impo eny i		Van	~ C.	Cin	e	8	128 U h	seray 1	Za Dan	dallsh	oun i	mo a	ral service
			23a. Part1. Enter the shock, or heart for	disease, or com ailure. List only	olications that	caused the dea			, .	s cardiac or	respiratory ari	rest,		Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nai	a. A	dult	Resp	irat	ory (	Distr	ess S	ynd	rome	Onset and Death
1	/Medical Examiner		rosoning in doding	ſ	Due to	(or as a consec	quence of):		,			′		
		Iner	Sequentially list condi- if any, leading to imme	adiate 📕	b. Due to	(or as a conse	quence of):							
8.	ecuted and transi	Exam	cause. Enter Underly Cause (Disease or inju- that initiated events resulting in death) Las		c	/								
),09 <u>/8</u>	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	al E	rooming in doding Edu		. Due to	(or as a conse	quence or):							
9	ificate g phys as the	edical			d									
Box	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pr			lcome of pregn		Ectopic pregna	ancy			23	3d. Date of del	
_	at the dea by the at tached fo	Physician/Me	in lhe past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	lo	4□Preg 9□Unkn	nant at time of		Other (specify					Month	Day Year
P.O.	res that the igned by be detact		Part II. Other significa	int conditions o	ontributing to d	leath but not re	sulting in the un	derlying cause	given in Part	I.	23e. Did to	bacco us	e contribute to	the cause of death?
rds	w requires been sign should be	ed by	Acut	e Re	nal	Fail	rre				1 □ Y	es 2	No 3□Pr	robably 4 Unknown
eco	e taw re hes be	Completed									24a. Was a	sy	24b. Were au	utopsy findings available completion of cause of
a B											perfor	med? 2 No	death? 1 ☐ Yes	× /
Χ	Physician: Tribis certificaral director, p	To Be	25. Was case referred examiner?  1 Tyes 2 No		Hospital: 1	Inpatient 2	] ER/Outpatieni	3□ DOA	Other		Check only or		☐Other (Spe	O(b)
J Of	ding Phys h. After this funeral dir		27. Manner of Death	•		of Injury oth, Day Year)	28b. Time of Injury		njury at Work?		d. Describe h			City)
siol	tendir leath. lor: Af the fu	catlo	2 Accident	5 Pending investigation 6 Could not be			le le	М	1 Yes 2					
Division of Vital Records,	Hospital or Attanding 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	4 Homicide	determined	289. Place	e of Injury - At h ling, etc. (Spec	ify)	et, factory, off	ice	28	if. Location (S City or Tow	itreet and n, State)	Number or Ru	ural Route Number,
	To the Hospital or Attantwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 (Check only 2 one)	Certifying Ph	niner: On the b	e best of my kn casis of examin nner stated.	owledge, death ation and/or inv	occurred at the estigation, in n	e time, date ar ny opinion, dea	nd place, an ath occurred	d due to the d at the time, o	ause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	To th Within To th comp	Me	29b. Signature and titl	A.	7 1	0 .	~		ense number	giorite	à	29d. Date	signed (Mont	4
•				insh	_				1671			41		-006
	5		30. Name and address	s of person who	completed cau balia	se of death (Ite	m 23a) (Type, I	Print)	e St.	, Ba	Itime	ore.	MD	21201
	Sta Registr		31. Date filed (Month,	Day, Year)	006 32.1	egistrar's Sign	aturby A	well			e "		1	21201

06-06991 Robert Locklear

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	F	tegistrar	cate of Death	Reg. No.	2006 200
Physician ical Examine	-	1. Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day September 16, 2	Year 0608 hrs
		ROBERT DEAN LOCKLEAR  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of I		County of Death
}	ı	603 South Ann Street	Baltimore		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	pirthday) If Under 1 Year If Under 2	24Hrs. 8. Date of Birth(MM/D	D/YYYY) 9 Birthplace (State or
Director		217-80-4554 1 x M 2 F 47  Usual Residence of Decedent	Yrs Months Days Hours	12/27/19	P58 Country MD
, any			vn or Location		10d Inside City Limits
Maryland 28a-f show d at once.	١	MD BALI	TIMORE		1 X Yes 2 No
Maryl 28a-1	Director	10e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?
th the Maryland 23a or 28a-f she notified at once		1923 E. BALTIMORE ST.	21231	US	
should be filed within 72 hours after death with the Maryland and Mental Hygene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Married 2 Married 12. Was Decedent Ever in U S Armed Forces?  1 Yes 2 X No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? ( Specify Yes or No- uerto Rican, etc.)	4 Race - American Indian, Black, White, NATIVE
after	ջ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify		pecify: AMERICAN
led within 72 hours a tygiene other than "naturation Medical Exami			<ul> <li>Decedent's Usual Occupation (Give kin during most of working life. DO NOT us</li> </ul>		nd of Business/Industry
in 72 han "	픮				
d 2 should be filed within 72 lith and Mental Hygene m 27 is marked other than anunatic event, the Medical	Completed	12TH	DRY WALL 18.Mother's I	Name (First, Middle, Maiden S	ONSTRUCTION urname)
Id be file Mental Hy narked o event, th	Be	OUIMBIE LOCKLEAR	MARC	GARET JONES	
hould be fill of Mental I is marked rite event,			19b. Mailing Address (Street and Number		or Town, State, Zip Code)
7 - 7 =		MARGARET LOCKLEAR	603 S. ANN ST., E	BALTIMORE, MD	21231
	- 1		e of Disposition (Name of cemetery, natory or other place)		ocation - City or Town, State NTSWAMP
permit Pages I and Department of He Important: If ite injury or other tr			NDYNE CEMETERY	09/23/06 TOW	
permit Page Department of Important: injury or oth	Ī	21. Signature of Funeral Service Licensee			, JR. FNRL. HM.
	1	fillsley char yo	2007-09 EASTER	N AVE., BALTI	MORE, MD 21231
hysician		23a. Part. Enter the disease or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as card	liac or respiratory arrest, shock	k, or heart Approximate Interva Between Onset and
/Medical xaminer			cion complicated by acut	e meumonia	Death
		or condition resulting in death)  Due to (or as a consequence of):			
	ا <u>ه</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
·		cause . Enter Underlying Cause (Disease or injury that initiated c.			
ed	ΞÏ	events resulting in death) Last  Due to (or as a consequence of):			
execu an and	ᇹ	VUNPENDED AMENDED itcm#23c DI	FT 07 00 0 15 15 010		
Teate be executed physician and the burial - transi	Medical	Item#23a,PJ	□,27,28a-f,perME,g860,		Date of delivery
rtifica ing ph as the	<u>ا</u> ا	3b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic p		fonth Day Year
e death certiff the attending ed for use as	<u>  iš</u>	Pregnant at time of death	5 Other (Specify)		
he dez	Physician	a a oursinowii		000 P 1111	
that th	ğ	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part i		se contribute to the cause of death?  No 3 Probably 4 V Unknown
quires en sign ald be	e G	Cocaine use		24a Was an	24b. Were autopsy findings available
aw renas be	읦	Atherosclerotic cardiovascular diseas	se	autopsy performed?	prior to completion of cause of death?
The l	Completed			1 ✓ Yes 2 No	1 Yes 2 No
certifi certifi sctor,	Be	25 Was case referred to medical examiner?	26 Place of Death (Ci	heck only one)	
hysic r this al dire	၉၂	1 ✓ Yes 2 No Hospital 1 Inpatient 2 ER/			ce 6 🗸 Other: Scene
After t		1 Natural 5 (Month, Day, Year)	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury	y occurred
Attend r death ector: by the	Įğ.	2 Accident Investigation Find 9/16/2006 F	Ind 6:00 am 1 Yes 2 X N	unc	
spital or Attending Physician: The law requires that thours after death meral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detach	ertification:	Suicide (A) Could not be	, farm, street, factory, office building, etc	28f Location (Street and or Town, State)	d Number or Rural Route Number, City 03 S. Ann Street
pspita hours mera y fille	아	Planting Political Politic			
To the Hospital or Attending Physician: The law requires that the death certification of hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral triescence, page 2 should be decaded for use as	ल	(Check only 1 Certifying Physician: To the best of my knowledge, cone) 2 Medical Examiner: On the basis of examination and/o			
To the within To the complete	Med	and manner stated  29b Signature and title of certifier	29c License number		ate signed (Month, Day, Year)
15210	-	his his mos	O.C.M.E.	_	ember 16, 2006
N. C.	-			Серк	
		<ol> <li>Name and address of person who completed cause of death (Item 23a Ling Li, MD Assistant Medical Examiner 111 Pe</li> </ol>	,	1	
		Od Data Statuta Cianta		<del></del>	
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	A 30 .		

<ul><li>State Registrar</li></ul>	State of	Maryland			of Health ar <i>of Death</i>	id ivien		erie Z. ( g. No.	ט ט נ	2992
Decedent's Name (First, Middle S HAR			LOCK	LEA	R	ا م	Date of Death Month Pemb	Day	Year <b>Zo</b> c	3. Time of Death
a. Facility Name (If not institution	n, give street and num	dical C	enter		wn, or Location of ltimore		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4c. County		
Social Security Number 214–56–9440		7. Age (In yrs. la . 56	st birthday) Yrs.	If Under 1 \		Min. (	Date of Birth Month, Day, 1		9. Birt Co	hplace (State or Foreign untry) MD
Usual Residence of Decedent  Oa. State  10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
MD BALT  Oe. Street and Number	IMORE	DU	NDALK	10f. Zip Co	ode		100	g. Citizen of	What Co	1 XYes 2 ☐ No ountry?
6768 WODLEY R	D.			212	222			USA		
1. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 🏾 Divorced	ned Armed For	2 [ <b>χ</b> Nο θ	1	Was Deceden f Yes, specify 1 □ Yes 2 2	t of Hispanic Origin Cuban, Mexican, No Specify:	n? (Specify Puerto Rica	Yes or No- n, etc.)		ck, Whit	orican Indian, e, etc. ATTVE IERICAN
15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1	-4or 5+)	(Give	dent's Usual C kind of work o DO NOT use i	done during most o	of working	10	6b. Kind of B	lusiness/	Industry
10TH			CAS	SHIER	1			CARR		
7. Father's Name (First, Middle, FRED NATLL	Last)					s Nam <i>e (Fil</i> IA V. 1	st, Middle, Ma WOODS	aiden Sumar	ne)	
9a. Informant's Name/Relations BARRY LOCKLEA					Street and Number				, State, 2 281	
	o []D	ce	ace of Dispo metery, cren	sition (Name natory or othe	of er place)	Date	20	5500 O	City or	Town, State
1 Burial 2 Commation 4 Donation 5 Other (S	pecify) Ligansee	State RA	YVIEW	CREMAT  Name and A	ORY 0 Address of Facility OSTER	9/23/ WESLE N AVE	06 I Y CHAV ., BALI	BALTIM IS, JR I'IMORE	ORE,	IRL. HM.
1 Burial 2 Cremation 4 Donation 5 Other (S  1. Signature of Funeral Service  1. Sa. Part 1. Enter the disease to shock, or heart failure. List mediate Cause (Final isease or condition	complications that control one cause on each	State RAT	YVIEW 22 Do not enti	CREMAT  Name and A	CORY 0 Address of Facility O EASTER of dying, such as ca	9/23/ WESLE N AVE	06 I Y CHAV ., BALI	BALTIM IS, JR I'IMORE	ORE,	MD 21224 IRL. HM. 21231 Approximate
1 Burial 2 Cremation 4 Donation 5 Other (S  11. Signature of Funeral Service  123a. Part1. Enter the disease of shock, or heart failure. List mmediate Cause (Final lisease or condition esulting in death)  Requentially list conditions, any, leading to immediate ause. Enter Underlying lause (Disease or injury latt initiated events	complications that control one cause on each of the control one ca	BA  BA  BA  BA  BA  BA  BA  BA  BA  BA	YVIEW  22  Do not entitle from the control of the c	CREMAT  Name and A  2007-0  er the mode o	CORY 0 Address of Facility O EASTER of dying, such as ca	9/23/ WESLE N AVE	06 I Y CHAV ., BALI	BALTIM IS, JR I'IMORE	ORE,	MD 21224 IRL. HM. D 21231 Approximate Interval Between
	complications that control one cause on each of the control one ca	State RA  BA  Queed the death.  Ach line.  CULA V  or as a consequence.	YVIEW  22  Do not entitle from the control of the c	CREMAT  Name and A  2007-0  er the mode o	CORY 0 Address of Facility O EASTER of dying, such as ca	9/23/ WESLE N AVE	06 I Y CHAV ., BALI	BALTIM IS, JR I'IMORE	ORE,	MD 21224 IRL. HM. D 21231 Approximate Interval Between
1 Burial 2 Cremation 4 Donation 5 Other (S  1. Signature of Funeral Service  1. Signature of Funera	complications that conty one cause on example to (b. Due to (d. Du	estate BA  BA  BA  CULG V  or as a consequence of as a consequence of pregnar and the consequence of the con	YVIEW  22  Do not entrement of the property of	CREMAT  Name and A  2007-0  er the mode o	CORY 0 Address of Facility 09 EASTER of dying, such as ca	9/23/ WESLE N AVE	06 I Y CHAV ., BALI	BALTIM IS, JR TIMORE	ORE,	MD 21224 IRL. HM. D 21231 Approximate Interval Between Onset and Death L day
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1 Burial 2 Cremation 4 Donation 5 Other (St. Signature of Funeral Service Shock, or heart failure. List mmediate Cause (Final disease or condition esulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last  FFEMALE:  3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  art II. Other significant conditions.	complications that conly one cause one  a. Ven'v  Due to (  b. Due to (  d. 23c. If yes, out 1   Live b 4   Pregn. 9   Unknowns contributing to de	State BA  BA  BA  BA  BA  BA  BA  BA  BA  BA	YVIEW  22  Do not entrement of the control of the c	CREMAT  Name and A  2007-Cer the mode of t	nancy  se given in Part I.	9/23/WESLE N AVE ardiac or res	23e. Did toba 1 Yes 24a. Was an autopsy performe	23d. Da Mc 23d. Da Mc 22 No 24b.	ate of delonth tribute to 3 □ Pr Were au prior to death? 1 □ Yes	MD 21224 IRL. HM.  21231 Approximate Interval Between Onset and Death 1 Jay  ivery Day  Year  the cause of death? obably  4 Denknown  itopsy findings available completion of cause of

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

**Physician** /Medical

Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "netural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

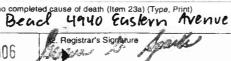
Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

State Registrar

Dr. Valeriani 31. Date filed (Month, Day, Year) 2006 SEP 2 1



Baltimore, MD 21224

29d. Date signed (Month, Day, Year)

19,2006

September

29b. Signature and title

29c. License number

D0063082

State of Maryland / Department of Health and Mental Hygiene 2006 29928 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** LAWSON · SHIPLEY 18:30 SEPT. 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE NIA OF MARYLAND MEDICAL CENTER UNIVERSITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2\C\X Yrs. 76 Director 214-26-0330 01 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic avent, It.a Medical Examiner must be notified at once. 1 X Yes 2 No Baltimore Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 740 Poplar Grove Street Apt 6F 21216 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ **X**Widowed 4 □ Divorced Specify. Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Private Duty L.P.N. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Amos 2 Herbert Shakespere 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20774 19a. Informant's Name/Relationship (Type, Print) 1205 Heritage Hill Dr., Upper Marlboro, Md Mrs James Laforest-Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, King Memorial Park 9/21/06 21. Signature of Fundal Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** DUCDENAL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consumence of physicien and Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, φ 1 Tes 2 No 3 Probably 4 Munknown Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? paga 1 ☐ Yes 2 ☐ No Division of Vital director 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 ☒ No 1 2 Inpatient 2 TER/Outpatient 3 DOA Sign 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 Pending after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 - Homicide To the Hospital c within 24 hours af To the Funeral D completely tilled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17384 M.D 9/16/06 30. Name a d address of person who completed cause of death (Item 23a) (Type, Print) 22 ST. Z1201 STEVENS 5 GRENE BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [ 29929 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1957 LAWSON 20 02 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER 401 055 HOSPITAL SPRING MONTGOMERY 7 C R If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **Director** MARYLAND none 022006 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "naturel", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Exemples 200.00. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Director SILUER MONTGOMERY SPRINC MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 0910 USA 1910 ROSEMARY DRIVE Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 No f Yes, Give 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CURTIS LAWSON KATRYNA LAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROSS HOSFIFAI 1500 POREST GLEN RD SILVER SPRING MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 🖾 Other (Specify) in state 21. Signature of Euneral Service Rona I State "Anatomy" Board 655 W. Baltimore Street Director 21201 m Baltimore, MD 23a. Part1. Enter the disease, or competications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician GROSS RUPTURE MEMBRANE /Medical Due to (or as a consequence of): **Examiner** PREMATU KIEEWE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy jo Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the tuneral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 948033 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOLANDA MAR 6201 GREENBELT RD, COLLEGE PARK MS ROBERTSON-HACKNEY 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

SEP 2

			1- For State of Registrar	f Maryland / Depa		th and Mental I	Hygiene Reg. No. 201	e. 06 29930
	Physici /Medic		Decedent's Name (First, Middle, Last)     WILLIAM RAY LOVE	E		2. Date of Month		3. Time of Death ear 8:55 P M
Ī	Examir		4a. Facility Name (If not institution, give street and nu HARBOR HOSPITAL	mber)	4b. City, Town, or Loca  BALTIMO	ition of Death	4c. County of  BALTII	Death
	Funeral Director		5. Social Security Number  216-60-5664  Usual Residence of Decedent	7. Age (In yrs. last birthday) 58 Yrs.		onder 24 Hrs. 8. Date of (Month Aug 2	Dav. Year)	. Birthplace (State or Foreign Country) Maryland
	Maryland f show	tor	10a. State 10b. County MD	10c. City, Town or Lo				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	deeth with the Maryland me 23a or 28a-f show round be notified at	I Director	10e. Street and Number 3707 S. Hanover Stree		10f. Zip Code 212	225	10g. Citizen of Wha	at Country?
5-0036	n 72 hours after deeth with the Marylan "natural", or itema 23a or 28a-1 show saltal Exomicar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Dec Armed Fc 1 Yes 1 Yes 1 Yes Year or D	2 DNo ve	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2X No Spe	ic Origin? (Specify Yes o exican, Puerto Rican, etc.		American Indian, White, etc. White
	d within 72 ho giene. ir then "natur ir e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)		16b. Kind of Busin	ness/Industry
	be filed tal Hygi d other event, t	To Be Co	11 0  17. Father's Name (First, Middle, Last)  Raymond Love			n Mother's Name (First, Mic acile Lillia		t
B	mit. Pages 1 end 2 should artment of Health and Men ortant: if tem 27 is marke injury or other treumatic.		19a. Informant's Name/Relationship (Type, Print)  Janet Brown/friend	3707	ng Address (Street and N S. Hanover	Street Bal	umber, City or Town, Statimore, MD	21201
_	it. Pages atment of h ortant: if its injury or of		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 🗓 Other (Specify) in St;  21. Signature of Europa Service Licensee	ate	natory or other place)	Date	20c. Location - Cit	
o O	Depart Depart Import any inj		21. Signature of Europai Service Licensee ROPAID S. Wade, D.  23a. Part1. Enter the disease, or complications that of	Ba	Itimore, MD	Board 655 N		e Street Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	nach line. TE RESPIRATI (or as a consequence of):				Interval Between Onset and Death
	Profision: The law requires that the death certificate be executed to the control of the control	dical Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of):	DEMA			Z DHYS
O. DOX 0	ures that the death centificate signed by the attending phys d be detached for use as the	Physician/Med	in the past 12 months?	ant at time of death 5	Ectopic pregnancy		23d. Date o Month	f delivery Day Year
r (Spin	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to de METABOLIC ACIDOSS		_			te to the cause of death?  Probably 4 Dunknown
מו חפנו	n: Inelaw r	Completed	HEPATIC DYSFUNCTION ANEMIA	ON, COAGIL	LOPATHY	a p	utopsy prior deal	e autopsy findings available to completion of cause of th? Yes 2[1] No
5	s certil	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Hospital:	mpatient 2 ☐ ER/Outpatient		Place of Death Check or Nursing Home 5 R		0
	of the novelled of Attending Physician: The law within 24 hours elfer deeth.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death  1 Natural 5 Pending (Monta) 2 Accident investigation	of Injury (h, Day Year)  28b. Time of Injury	28c. Injury at Work? M 1 Yes	28d. Descri	be how injury occurred	Specily)
	urs efter de rei Directo	Certification;	4 Homicide documents buildi	of Injury - At home, farm, streng, etc. (Specify)		City or	en (Street and Number of Town, State)	
:	the hosp hin 24 hou the Fune hpletely fi	ledical		best of my knowledge, death asis of examination and/or inv ner stated.	estigation, in my opinion,	, death occurred at the tir	the cause(s) and manne ne, date and place, and	or as stated. due to the cause(s)
1	To To	Σ	29b. Signature and title of certifier	D	29c. License numb		29d. Date signed (N	
			30. Name and address of person who completed caus		Print)			ER, 10,2006
	Sta	10	SETAL PATEL, 3001 S 31. Date filed (Month, Day, Year)  SEP 2 1 2006	OUTH HANOV	ER STREET	BALTIMO	RE, MO2	1225
	Registr	ar	SEP 2 1 2006	was to figure	a comment			

			Pleas	e Type or Print i				•	•	
			1 - For State Registrar	State of Mary		epartment of F Certificate of			ne . No. 2006	29931
	Physici	an	Decedent's Name (First, Middle,     DONALD	MACLE	AN			2. Date of Death Month	Day Yeer	3. Time of Death
	/Medio		4a. Facility Name (If not institution,		-1(14	4b. City, Town, o	or Location of Death	SEPT	17 2006 4c. County of Death	<u> </u>
	LXamii	ici	SINAI HOSP	TAL OF BAL	TIMOR	E BALT	MORE		NI	9
	Funeral Director		020-05-8177	. Sex 7. Age (In	yrs. last birth	Months Days	Hours Min.	8. Date of Birth (Month, Day, You March 19, 1	9. Birth Cou	place (State or Foreign intry)
	land ow		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at	ctor	MD N	la		BALTIMO	ne			1 Yes 2 No
9	with th	Director	10e. Street and Number	6.		10f. Zip Code	0 - 011	10g.	. Citizen of What Cou	untry?
F	eath v	Funeral	7005 YARK	12. Was Decedent Ever	rintts	13 Was Decedent of H	21234	offy Yes or No-	U - S - A	ican Indian
00NALD 1036	after d		1 Never Married 22 Married	Armed Forces?		13. Was Decedent of # If Yes, specify Cub		lican, etc.)	Black, White	, etc.
	urel', c	d by	3 Widowed 4 Divorced	tt Yes, Give Year or Dates:	ARMY	1□ Yes 2⊡No	Specify:		Specify: W	hite
ACLE AN DO Maryland 21215-0036	n 72 h	Completed by	15. Decedent's (Specify only highest	Education grade completed)	1 (0	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	during most of workin	9 161	b. Kind of Business/li	ndustry
Æ\212	filed with Hygiene. other ther	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)		Teac	,		CITY SC	hools.
nd Pu	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Name		,	
Z S	2 should be and Mental Is marked of aumatic ev	은	PETER MACIE  19a. Informant's Name/Relationship		105.1	4-11-	ROXANA			
A Ma	and 2 sho ealth and n 27 ls m		-4-1	elean		Mailing Address (Street	DRIVE PA		21234	р Соав)
ē Z	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition	2	Ob. Place of D	isposition (Name of crematory or other pla	COL DE	ate 200	c. Location - City or T	own, State
$\mathcal{M}$ Baltimore,	Pege ment ( ent: If		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Morela	ND Cem.	9(21)		Alto. MD.	
Ball	permit. Peges 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tra once		21. Sign stars of Funeral Service Lie	ensee		2. Name and Address Aut STEIL	ess of Facility A Funeral	Home, 1	PA	
			23a. Part . Enter the disease, or co	emplications that caused the	death. Do no				NO 21734	Approximate
	Physician	IJ	shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each line.	SIC					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of)					2 0013
- 18	LAGITITIE	16	Sequentially list conditions, if any, leading to immediate	b. ANAU		RCINOM	A			lyr.
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					~
60,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a co	nsequence of)					
3876	icate b physic the b	dica		d						
ox 6	eath certificate be exattending physicien for use as the buria	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of deliv	rery
Division of Vital Records, P.O. Box 687	The law requires that the death certificate be executed as bas been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	<i>y</i>		Month	Day Year
ر. م.	uires that the de signed by the a id be detached f	by Ph	Part II. Other significant condition	s contributing to death but no	ot resulting in the	ne underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been si should b	ted						1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
Rec	: The law cete has b , page 2 si	Completed						24a. Was an autopsy performed	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
ta	iicien: Th certificete rector, pag	0	25. Was case referred to medical				26. Place of Death	1  Yes 2 (Check only one)	No 1 ☐ Yes	2 No
) \	Physicien: r this certifice ral director, p	To B	examiner? 1 ☐ Yes 2 No		2 ER/Outp	atient 3 DOA	ner: 4 ☐ Nursing Hom		e 6 Other (Speci	fy)
o uc	ding Pt h. After th funeral	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Tin Inju	ne of 28c. Injui	yat rk? Yes 2 □No	8d. Describe how		
visio	Attender deatlecter:	Certification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	be 28e. Place of Injury -	At home, farm	, street, factory, office			t and Number or Rur	al Route Number,
	ital or urs afte ral Dir iled in	Cert		building, etc. (S				City or Town, S		
	To the Hospital or Attending Physicien: Within 24 hours after death.  A othe Funeral Director: After this certifice completely filled in by the funeral director, g	ledicai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my eminer: On the basis of exa and manner stated.	y knowledge, o mination and/	leath occurred at the til or investigation, in my o	me, date and place, are opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
_	To the later 2 rougher complet	Me	29b. Signature and title of certifier			29c. Licens			Date signed (Month,	
	D .		29b. Signature and title of certifier			1 18	S 000	S	EPT, 1	7,2006
	10		30. Name and address of person w	o completed cause of death	(Item 23a) (T)	rpe, Print) Haspita	the of BA	ALTIMORE	£	
5	Sta		31. Date filed (Month, Day, Year) SEP 2 1 2	39 Registrar's						
	Registr	ar	AFLATE	and a second	1 4 g					

06-06937

Please Type or Print in Black Indelible Ink

Vyatt	Lee Marse		Registrar	epartment of Hea Certificate of Dea		Re	g. No. 200	6 2993
Physician/ Medical Examiner			1. Decedent's Name (First, Middle, Last)  WYATT - L. MARSE	00		2. Date of Death Month September	Day Year 14, 2006	3. Time of Death 1530 hrs
			4a. Facility Name (if not institution, give street and number)	4b. City	. Town, or Location of		4c. County of Death	
			3129 Walford Drive Apartment E  Dundalk  5 Social Security Number  6 Sex  7 Age (In vrs. last birthday)  If Under 1 Year If Under 24Hrs. 8 Date of Birth				Baltimore County  h(MM/DD/YYYY) 9. Birthplace (State or	
Funeral Director			213-82-9300 1VM 2 F 35 Yrs Months Days Hours Min AUGUST 9, 1971 Foreign Country) MD					
	more, MID 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mental Hygiene in the Maryland Hygiene in the most is narked other than "natural", or items 23a or 28a-f show any or other traunatic event, the Medical Examiner must be notified at once.	or	Tod. Othy Territor Estation					10d. Inside City Limits
			MD BALTIMEN	Dun	DALK			1 Yes 2 No
		rect	10e. Street and Number APT. E	10f. 2	Zip Code	10	g. Citizen of What Count	ry?
		a D	3129 WAITFORD DR.  11. Marital Status  12. Was Decedent Ever	in U.S. 13. Was Dece	21772 dent of Hispanic Orig	in? ( Specify Yes or No-		an Indian, Black,
	death w	Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2	No If Yes, spe	cify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	,
after o		by F	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes	2 No specify:	ind of work dono	Specify U. I	riTe
	2 hours "natu	ted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)		vorking life. DO NOT			
036	Datulliors, MID 2 12 13-00-00  The same Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	To Be Completed	12th N/4	MA	NA que			Ain
15-0			17. Father's Name (First, Middle, Last)  JAMES MARSEE		18.Mother	s Name (First, Middle, M	laiden Surname)	
212	d 2 should be fil th and Mental I- n 27 is marked umatic event, i		19a. Informant's Name/Relationship (Type, Print )		ess (Street and Num	ber or Rural Route Num	ber, City or Town, State,	
5	and 2 shou lealth and I tem 27 is traumatic		Michael MARSER				20c. Location - City or	
a d	ages land 2 int of Health nt: If item 2 other traun		1 Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (No crematory or other pla	ce)	9 21 06		
į.			4 Donation 5 Other Specify 21. Sugnature of Funeral Service Licensee	BAYVIEW Cr	enatory		BALton	ν
g.	permit Departin Importi		Mul M. Stills PAUL STELLA FOREST RD. BALLO: MO 21234					
	hysician		23a. Hart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and					
-	/Medical Sxaminer		Immediate Cause (Final disease a Narcotic intoxication presulting in death)  Due to (or as a consequence of):					
			Sequentially list conditions,  b					
	J.	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal E	d.  WUNDENDED AMENDED 1100 07 00 0 NE 070 0 100 100 100 100					
9		Medi	IF FEMALE:  AMENDED  item#23a,27,28a-f,perME,g859,9/22/06 TT  23d Date of delivery					
587		ian/I	23b. Was decedent pregnant in the past 12 months?	2 Fetal dea		pregnancy	Month D	ay Year
Š		Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown	of death 5 Other (S	ресіту)		*	
		by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the underly	ing cause given in Pa	irt I. 23e. Did to	bacco use contribute to t	F
٥		ed b		· · · · · · · · · · · · · · · · · · ·		24a Was		opsy findings available
7		Completed				autop perfor	sy prior to comed? death?	ompletion of cause of
٥			25 Was case referred to medical		26.Place of Death	(Check only one)	2 No 1 Ye	s 2 No
		o Be	examiner? 1 V Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other A Nursing Home 5 Residence 6 Other Scene					
) 3		n: T	27. Manner of Death  28a Date of Injury (Month, Day, Year)  1 Natural 5 Pending Particles 1 1 1 2 05 1 1 Yes 2 1 No					
ر از		catic	2 Accident Investigation 28e Place of Injury	006   Fnd 3:25 p			Street and Number or Ru	al Route Number, City
		Certification:	Accident  3 Suicide 6 X Could not be determined (Specify) found in residence  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Town, State) 3129 Wall (Specify) found in residence					rd Dr.
		Medical C	29a Certifier (Check only one)  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
			and manner stated.  29b. Signature and title of certifier  29c. License number				29d. Date signed (Month, Day, Year)	
			Carol Hallon		O.C.M.E.		September 15, 2	006 
	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Stave 31. Date filed (Month, Day, Year) 32. Egistrar's Signature								
Registrar SEP 2 1 2006 Account to the second								

			1 - For State Registrar	State of	of Marylar		artment of F		d Mental Hy	giene Rog. No. 200	6	29933
	Physici	án	1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath	/ear	3. Time of Death
6 ,	/Medi	cal	Sohpia F. Mor			······			Sept.	19, 200	6	1:30 p. M
*57	Examir	ner	4a. Facility Name (If not institution 1705 Drexel Re		imber)		4b. City, Town, o	r Location of L dalk	eatn	4c. County of Baltin		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24				ice (State or Foreign
	Director		216-32-7642	1□M 2XTF	93	Yrs.	Months Days	Hours	Min. (Month, Day			y) zland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					d. Inside City Limits
	Maryl f sho	Ö	Manueland Dal	timore							1.50	1 ☐ Yes 2√0XNo
	r 28a	Funeral Director	Maryland Bal  10e. Street and Number	CTHOL6		Dundal)	10f. Zip Code			10g. Citizen of Wh	at Countr	y?
	15 will	ai D	1705 Drexel Ro	ad			21222			United :	State	es
	r dea	ner	11. Marital Status	Armed Fo	edent Ever in U		Was Decedent of H	ispanic Origin' an. Mexican. P	? (Specify Yes or No-		American White, etc	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28s-f show event, the Medical Exercities Lives the multiled at	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve		I□Yes 2¼ No	Specify:	,	Specify:		
21215-0036	2 hou	ed	15. Deceden		74183.	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busin	White	
212	ihin 73 Bra "na Medil	Completed	(Specify only highest Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+)	(Give	kind of work done of NOT use retired	during most of	working	Too. Tand of oasi	iosarii da.	Stry
	ed wil	Con	8 years			Hair	Dresser/			Beautic	ian	
Maryland	be fill tal H d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle,	Maiden Sumame)		
ž	d Mer d Mer marks marks	ို	Unknown 19a. Informani's Name/Relations	hin (Tuno Print)		10h Mailie		Unknov				
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Extraired the rutilised at ODGe.		Bernard Sachs	Attorne					r Rural Route Numbe			,
ē,	s 1 ar f Hea ltem other	1	20a. Method of Disposition	Persona'	20b. F	Place of Dispo	Gardervi		Date Date	re Mary		
Ë	Page nent o nt: ff ry or		1 ☐ Burial 2 ☐ Gremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from	State		natory or other place	, I	9/21/2006	tilood I arin	o M=	bacland
Baltimore,	permit. Departminitimporta		21. Signature de vineral Service			// 22	. Name and Addres	ss of Facility				MARKET OF THE TOTAL
<u>-</u>	80 E 8 8		Mark	11/6	W/	79	22 Wise	Avenue	l Home of Dundalk,	Maryland	Inc.	
		١.	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	caused the deat each line.	th. Do not ente	er the mode of dyin	g, such as car	diac or respiratory arr	rest,	- In	approximate nterval Between
6.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Colo	n C	un Ces					Inset and Death
	Examiner			Due to	(or as a conseq	uence of):						
**	****	er	Sequentially list conditions, any leading to immediate cause. Enter Underlying	b. Due to	(or as a consul	menne off:					_	
14	cuted	Examiner	Cause (Disease or injury that initiated events	c								
0,	cate be executed physicien and the burial-transit	EX	resulting in death) Last	Due to	(or as a conseq	quence of):	_					
8760,	icate be executed physicien and s the burial-transit	dicat		d.							-	
9 X	that the death certifii ed by the attending i detached for use as	/Me	IF FEMALE:	23c. If yes, ou	tcome of pregna	ancv						
Вох	death a atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live t	ointh 2 ☐ Feta nant at time of d	ıl death 3 □	Ectopic pregnancy Other (specify)			23d. Date o Month	,	
о. О	t the c by the	hys	9 Unknown	9□ Unkn	own							
S,	S 5 9	by Physician/Me	Part II. Other significant condition	ens contributing to d	eath but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribu	ite to the	cause of death?
ord	w require been si should I								1 🗆 Y	es 2-DNo 3[	] Probabl	ly 4 ∐Unknown
Records,	e law has b	Completed							24a. Was a autops	n 24b. Wei	e aulopsy	y findings available letion of cause of
									perfori	med? / dea	th?	□No
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			3D DOA Othe	_	Death Check only on			
ō		2:	1 ☐ Yes 2 ☑ No 27. May ler of Death	101	Inpatient 2 of Injury th, Day Year)	ER/Outpatient 28b. Time of	3000	4 🗀 INUISIN	g Home side	ence 6 Other (	Specify)	
0	nding Phath.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	3	th, Day Year)	Injury	28c. Injury Work M 1 □ \	r? Yes 2 □ No		and any observed		
Division	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 288. Place	of Injury - At ho	ome, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Number of	or Rural R	loute Number,
ā	itslor rrs afte ref Dir			1								
	To the Hospitsl within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the b	asis of examina	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and planting	ace, and due to the cocurred at the lime, d	ause(s) and manne ate and place, and	er as state	ed. e cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and man	ner stated.	-	29c. License			9d. Date signed (A		
	⊢ ≯ ⊢ ŏ		1 June 23	man .			0000	59189	1	9-20-	م د	Fi Tour/
	3	1	30. Name and address of person	who completed caus	e of death (Item	n 23a) (Type, F	Print)		`			
			Sirring S.B	arron	MD 7	ozh	1.40h	St (	Baltimore	NO 212	11	
*	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture	N. a		Saltimore			
3	Registra	ar	SEP 2 1 21	006	US. 55.	Good						

			For State Registrer	State	of Mar	yland / I	Depa <i>Cer</i>	rtment of H	lealth and Death	Mer	ntal Hyg	giene Reg. No.	2006	29934	ł
	Physicis	20	1. Decedent's Name (First, Middle	, Last)						2.	Date of Dea Month	ath Day		3. Time of Death	
	Physicia /Medic		HARRY MC	HUDY							SEP	17	2001	6 1220 PM	
	Examin	er	4a. Facility Name (If not institution					4b. City, Town, or		ath		4c.	County of Dea	ith	
			UNIVERSITY OF N					If Under 1 Year	MORE If Under 24 H	re o	D-1	<u> </u>	N/A		
	Funeral		5. Social Security Number	6. Sex 1 <b>X</b> M 2 □ F		'In yrs. last bi	Yrs.	Months Days	Hours Mi	in.	Date of Birt (Month, Da)		C	thplace (State or Foreign ountry)	
	Director		Usual Residence of Decedent		60	)				⊥S	ept.	23,	1945Wes	st. Virginia	_
	land Iow		10a. State 10b. County		1	IOc. City, Tov	vn or Lo	cation						10d. Inside City Limits	
	Mar	tor	Maryland Balt	imore		Balti	mor	e						1 ☐ Yes 2 ☑ No	
	th the	Director	10e. Street and Number					10f. Zip Code				10g. Citiz	zen of What C	ountry?	
	238 c	aiD	7908 Gough Str	eet				21224				Uni	ted Sta	ites	
	eme eme	Funeral	11. Marital Status	12. Was De Armed F		er in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify	Yes or No- an, etc.)		14. Race - Ame Black, Whi	erican Indian,	
2	or it	by Fu	1 Never Married 2 Marri	If Yes, G	2 <b>∑</b> No Sive		1	☐ Yes 2☑ No	Specify:				Specify:		
Ś	urel	d D	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:	1 10-		landa Haral Oan			i	10h Ki-		nite	
2	n 72	Completed	15. Decedent (Specify only highes	t grade completed			(Give i	lent's Usual Occup kind of work done o DO NOT use retired	during most of w	vorking		16D. Kir	nd of Business	vindustry	
7	withi ene. then	d L	Elementary/Secondary (0-12)	College	(1-4or 5+)						~	Cor	nstruct	rion	
3	Hygi Hygi other		9 years 17. Father's Name (First, Middle,	Last)			leav.	y Equipme	18. Mother's N					.1011	_
Ö	ld be ental ked o	To Be	William Carl M	cavov s	r				Bessie	Δν	onholi	+			
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 le marked of Hygiene. Other traumatic event, the Macdical Examination at the notified at	-	19a. Informant's Name/Relations			191	b. Mailin	g Address (Street					Town, State,	Zip Code)	_
Š	and 2 ealth a n 27 le		Roy McAvoy	(Brothe	r)	7	7908	Gough St	reet	Bal	timore	e. Ma	aryland	21224	
בי ב	of Health item 27 I		20a. Method of Disposition	o.□D14		20b. Place of	of Dispos	sition (Name of natory or other place		Date			cation - City or		
altillo	Pages nent of h ant: If its ury or of		1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State	Oak I	awn	Cemetery	,   9/	/22/	2006	Balt	timore,	Maryland	
<u></u>	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service	Lizensae	7 00	2	22	. Name and Addres	ss of Facility						
۵	82 = 9		V/Z		all		7	uda-Ruck 922 Wise	Funeral Avenue	L Ho	me of ndalk	Duno Mai	dalk, I rvland	nc. 21222	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the	ne death. Do							7	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	. Mu	LT11	SBAR	PN	EUMON(A						Onset and Death	
	/Medical Examiner		resulting in death)	Due to		consequence									
	Lxammer		Sequentially list conditions,	b	- (	consequence	-4\								_
7	Par His	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C Due to	o (or as a	consequence	101):								
	and al-trar	xan	that initiated events resulting in death) Last	c	o (or as a	consequence	of):								_
0000	cate be executed physician and the burial transit	dicai E		l.											
		edic		u											_
5	andin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			. 2□	Catania accessor				2	3d. Date of de	livery	
0	death	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at tir	Fetal death		Ectopic pregnancy Other (specify)					Month	Day Year	
?	by the	hys	9 Unknown	1						1					_
ก์	gned be de	by F	Part II. Other significant condition		death but	not resulting	in the un	nderlying cause give	en in Part I.					o the cause of death?	
5	equir sen si ould		HSV MENING	715						- [	1 🗆 Y	/es 2[	]No 3∏P	robably 4 Unknown	
	law r as be	Completed								_	24a. Was autop		24b. Were a prior to	utopsy findings available completion of cause of	
_	The sate h	Con									perfo	rmed? 2X No	death?	s 2 No	
100	clan: ertific ector,	Be	25. Was case referred to medical examiner?						26. Place of D	eath (C	heck only o	ne)			_
5	hysi this c	ို	1 ☐ Yes No		Inpatient				4   Nursing	-			Other (Spe	ecify)	_
	ling F	lon;	27. Manner of Death Natural 5 Pendin	g (Mo	e of Injury onth, Day 1		Time of Injury	28c. Injun Worl		280	. Describe h	now injury	y occurred		
VISION	death death stor:	Icat	2 Accident investig	not be 200 Blo	oo of Injun	. At home f	arm etre	eet, factory, office	Yes 2 □ No	281	Location /9	Stroot and	d Number or O	ural Route Number,	
3	after Direction by	Certification:	4 Homicide determ	buil buil	ding, etc.	(Specify)	um, suc	set, factory, office		201.	City or Tou	vn, State)	)	arar rioute rearriger,	
	spitel ours neral filled		29a. Certifier Certifyin	g Physicien: To the	he best of	my knowledg	e, death	occurred at the tin	ne, date and pla	ice, and	due to the	cause(s)	and manner a	s stated.	
	To the Hospitel or Attending Physician: The law requires that the death certify within 24 hours attended to the thin 24 hours attended to the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical one)	Exeminer: On the	basis of e	xamination a	nd/or inv	estigation, in my o	pinion, death oc	curred	at the time,	date and	place, and du	e to the cause(s)	
	withir To th	ž	29b. Signature and title of certified	r				29c. Licens	e number			29d. Date	e signed (Mon	th, Day, Year)	
			Hard A	Clubs	~ W			41764	35-15	326	2	SEP	17 2	2006	
	12		30. Name and address of person	who completed ca	use of dea	th (Item 23a)	(Type, I								
			PAUL G- K		no		nms		GREE	NE	25				
	Sta		31. Date filed (Month, Day, Year)	200	Registrar'	s Signature	Lan	K 2							
	Registr	al	SFP 2. 1. 21	uub Ale	250	A A	The state of								

DHMH 17 Rev 1/2001

		1 - State Registrar	tate of Maryland	•	rtment of tificate of		F	Reg. No. 20			
Physici /Medio Examin	cal	Decedent's Name (First, Middle, Last)     Eileen L. Manning     Aa. Facility Name (If not institution, give street in the content of the			4b. City, Town,	or Location of De	2. Date of Dea Month Sept.		Death		
Funeral Director		Stella Maris  5. Social Security Number  217-20-4524  Usual Residence of Decedent	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H			9. Birthplace (State or Ford Country) MD		
72 hours after death with the Maryland natural, or items 23e or 28e-f show lical Examiner must be notified at	Director	10a. State 10b. County MD Baltimore		Town or Lo					10d. Inside City Lin 1 ☐ Yes 2X		
ath with ir	ral Dire	2300 Dulaney Valley				1093			USA		
o within 7.2 hours after death with the Marylar Jiene. Then "netural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at	by Funeral		Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Vas Decedent of Yes, specify Cut		(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc. white		
	Completed			(Give life. L	ent's Usual Occu kind of work done OO NOT use retire	during most of w	vorking	16b. Kind of Busi	ness/Industry  Home		
od othe	To Be Co	17. Father's Name (First, Middle, Last) Michael McGuiness	II/ a	Troine	smarc I		ame (First, Middle, t Elizabe	Maiden Sumame)	)		
Health ar		19a. Informant's Name/Relationship (Type, Daniel T. Manning/sc 20a. Method of Disposition	n	121 Sa	-	Rd., Fa	wn Grove,	PA 1732			
ant: If		X Burial 2 □ Cremation 3 □ Rem 4 □ Departion 5 □ Other (Specify)  21. Signature 1 Funeral Service (fice see		Vet. Cem	ome of Dulaney Valley, Inc., Timonium, MD 21093						
hysician and was a case of the pricial strains transit	edical Examiner	Bryan M. Clary  23a. Part 1. Enler the disease, or complicat shock, or heart failure. List only sue of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence to	ence of):	allure Diabe	ing, such as card	ac or respiratory and	rest,	Approximate Interval Between Onset and Death M Onthis		
y th	Physiclan/Med	in the past 12 months?	If yes, outcome of pregnar 1□Live birth 2 □ Fetal 4□Pregnant at time of de 9□Unknown	déath 3 🗆	Ectopic pregnand Other (specify)	ey .		23d. Date Month			
as been signed b 2 should be deta	þ	Part II. Other significant conditions contrib	uting to death but not resu	iting in the ur	iderlying cause gi	ven in Part I.			ute to the cause of death?  Probably 4 Unkno		
ate ha	Completed						24a. Was a autop perfor 1 \( \text{Yes} \)	sy prie med? dea 2.⊠No 1.□	ere autopsy findings availa or to completion of cause ath? ] Yes 2 X No		
ath. r: After this certifical e funeral director, p	examiner?  1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4 Nursing Hor							ath Check only one)  Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
urs after death. irel Director: Afte	Certification:	4   Homicide	28e. Place of Injury - At hor building, etc. (Specify)	)			City or Tow	n, State)	or Rural Route Number,		
within 24 hours after of To the Funeral Direction of Management of the Funeral Direction of the	Medical	29a Certifier (Check crify 2 Medical Examiner: 29b. Signature and title of certifier	On the basis of examinati and manner stated.	vladge danth ion and/or inv	estigation, in my	ma, date and pla opinion, death oc se number	curred at the time, o	date and place, an	not as statud. d due to the cause(s)  Month, Day, Year)  Noten 18 th 20		
Sta	te	30. Name and address of person who comp ERNESTINE WRIGHT, 31. Date filed (Month, Day, Year)		ULANE	Print) VALLEY	ROAD T	IMONIUM,	MD 21093			

10:15 A.M.

SEPTEMBER 17, 2006

EILEEN MANNING

			1 - For State Registrar	State of Marylan		artment of H tificate of L			ene 200	6 29936
	Physici		1. Decedent's Name (First, Middle, Last) William Morreale					2. Date of Death Month Sept.	Day Yes 10 200	
	/Medio Examir		4a. Facility Name (If not institution, give s 5350 Porters town	Road		4b. City, Town, or Keedysy	ville	th	4c. County of D	eath
	Funeral Director		5. Social Security Number  220-38-2835  Usual Residence of Decedent	7. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	Birthplace (State or Foreign Country) ew York
	e Maryland la-f ehow	ctor	10a. State 10b. County  MD Washing		y, Town or Lo Keed	cation ysville				10d. Inside City Limits 1 ☐ Yes 2☐ No
	th with th	al Director	10e. Street and Number 5350 Porterstown	Road		10f. Zip Code	21756	1	g. Citizen of What USA	Country?
980	be filed within 72 hours efter death with the Maryland hal Hyglane. do other than "natural", or flems 23e or 28e-f ehow event. The Medical Exactical must be notified at	by Funeral	11. Marital Status 1  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	<ul> <li>12. Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ul>	l'	Was Decedent of Hi f Yes, specify Cuba I □ Yes 2⁄͡रो No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	mencan Indian, hite, etc. white
Maryland 21215-0036	within 72 ho ane. Ihan "natur ia Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done o OO NOT use retired,	furing most of wo	orking 1	6b. Kind of Busine	
land 2	should be filed and Mental Hygis marked other umatic event.	To Be Co	12 17. Father's Name (First, Middle, Last) Vincent Francis M	4 [orreale	sei	f employe	18. Mother's Na	me (First, Middle, M Sambuche		ince
	and 2 Health a m 27 lo		19a. Informant's Name/Relationship (Type)  Dee Morreale/spouse 20a. Method of Disposition	se	5350			ural Route Number,  Keedysvi Date 2		21756
altimore,	permit. Pages Department of H Important: if Ite any injury or of once.	1	1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. ig tur of Euneral Service License  KONA Id S. W	emoval from State	emetery, cren	natory or other place		d 655 W.	,	
ñ	Per Per Per Per Per Per Per Per Per Per		23a. Part 1. Enter the disease, or complice shoot, or heart failure. List only on	rations that caused the deat	- Ba	1timore.	MD 212	01		Approximate friterval Between
2.56	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		Ce U	Corcin	d ma	of Bla	dde-	Onset and Death 2 years
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
O. Box 6	death certifi e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
rds, P.	law requires thet the as been signed by th 2 should be detache	Ď	Part ff. Other significant conditions conf	tributing to death but not res	ulting in the ur	iderlying cause give	n in Part I.	23e. Did toba		to the cause of death?  Probably 4 □Unknown
al Records,	The ete h page	Completed						24a. Was an autopsy perform	ed? prior t	autopsy findings available o completion of cause of ? es 2 \( \) No
of Vital	Physician: Th this certificete al director, pag	To Be	1   185 2   140		ER/Outpatien		r: 4 ☐ Nursing I	ath Check only one	nce 6 Other (S	oecify)
Division of	eath. or: After the funer	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		at ? ′es 2 □ No	28d. Describe how		
2	pital or Att ours efter d eral Direct filled in by t		4 Homicide determined	28e. Place of fnjury - At he building, etc. (Specification)	y) 			City or Town,	State)	Rural Route Number,
	To the Hospital o within 24 hours eft To the Funeral Di completely filled in	Medical	(Check only one)  2 Medical Examin  29b. Signature and title of certifier	ician: To the best of my kno ler: On the basis of examina and manner stated.	tion and/or inv	estigation, in my op	inion, death occi	urred at the time, da	te and place, and d	ue to the cause(s)
)	7 3 7 8		michael J.	Aulans	MO			!	-	
				1 Clormede	1111	o Mei	leel	Compes	1dajes 1	06 mm MO.
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 2006	32. Registrar's Signa	iture	all of				

		for State Registrar	State of Maryla		artment of I			giene Reg. No. 2	0.0	20027
Physic	cian	Decedent's Name (First, Middle, Las     McComas	t)				2. Date of De Month	ath Day	Year	3. Time of Death 2:08 PM
/Med Exam	lical	4a. Facility Name (If not institution, give	2 1 1 1 1	Center		or Location of Dea	Septemb	4c. County	2006 y of Death	2.08 IM
Funera Directo		5. Social Security Number 6. 90 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	`	s. last birthday, Yrs.			8. Date of Bir (Month, Da NOV • 20	, 1953	9. Birthp	lace (State or Foreign try) yland
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimo		City, Town or L	ocation )undalk				10	0d. Inside City Limits
with the a or 28a	Director	10e. Street and Number 3505 Sollers	Point Dd		10f. Zip Code	21222		10g. Citizen of		try?
Baltimore, Maryland 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-1 show any nlury or other traumatic event, the Madical Examinar most be indifficed at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1	U.S. 13.	Was Decedent of I If Yes, specify Cub		Specify Yes or No rto Rican, etc.)		ce - Americ ck, White, (	etc.
Maryland 21215-0036 nd 2 should be filed within 72 hours aff lith and Mental Hyglene. 27 ie marked other than "naturel", or rtraumatic event, the Madical Exemp	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retire IEMAKEY	pation during most of wo d)	orking	16b. Kind of B		lustry
/land uld be file wental Hyg rikad oth	To Be C	17. Father's Name (First, Middle, Last) Walter	0.	Ha]	7	18. Mother's Na Marj	ime (First, Middle Orie	, Maiden Sumar		laas
and 2 sho salth and I n 27 le m		19a. Informant's Name/Relationship (7 AMON MCCOMAS (S	pouse)	3505	ing Address (Street	Point R	d. Dunda			•
Baltimore, permit. Pages 1 a Department of Hea mportant: if Item iny njury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		osition (Name of matory or other pla Cematory	1	Date 22-06	20c. Location		
Balti pemit. Departm Imports		21. Signature Funeral Service/Liren	see	2	2. Name and Address	ss of Facility S	tallings	Funeral	Home	e PA
Physician /Medica		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Sepsis		ter the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760, tate be executed Example by special and the burial-transit	dical Examiner	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Heatic Civilians a conse	rhosis						years
IS, P.O. BOX 6 res that the death certific igned by the attending p be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[	⊒Ectopic pregnanc ⊒ Other (specify) _	y			ate of deliver	ry Day Year
cords, P.O w requires that the been signed by the should be detache		Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	underlying cause gr	ven in Part I.		obacco use con Yes 2 No	tribute to the	e cause of death?
Rec The law te has b	Completed	2.211					24a. Was autop perfo 1  Yes	rmed?	Were autop prior to con death? 1 \( \text{Yes} \)	psy findings available apletion of cause of 2 No
of Vital F Physician: Th riths certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only o			
Vision of Attending Physic death. ector: After this by the funeral di	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	4 🗀 Nursing	Home 5 Resident	dence 6 Oth		)
Divisite Nospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (: City or Tox	Street and Numb vn, State)	ber or Rural	Route Number,
To the Hospital or within 24 hours at To the Funsral D completely filled in	edicai	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, dear nation and/or in	th occurred at the ti	me, date and place pinion, death occ	e, and due to the surred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
To th Withir To th	Me	29b. Signature and title of certifier	2 Any Stump	YD	29c. Licens	se number		29d. Date signe		
H		30. Name and address of person who of Amu Stump University	completed cause of death (Ite	эт 23а) (Туре,		) St 13	altimore			0 2006
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sign		Corde				,	

Matthews, Cariton

			State of Maryland / Depart		Mental Hygier	ne 2006 29938
			Registrar  1. Decedent's Name (First, Middle, Last)	ficate of Death	Reg. I	110,
	Physici /Medic		CARLTON BERNARD MATTHEWS			Day 17 2006 9. P M
İ	Examin	er		b. City, Town, or Location of Death Glen Burnie	•	4c. County of Death Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9 Birtholace (State or Foreign
u	Director		212-32-9755 1 <del>X</del> M 2 F 76 Yrs. M 2 Susual Residence of Decedent	Months Days Hours Min.	(Month, Day, Yea 04/26/1	9. Birthplace (State or Foreign Country) MARYLAND
	yland		10a. State 10b. County 10c. City, Town or Locat			10d. Inside City Limits
	ler death with the Marylan Items 23a or 28a-f show Instringst be coulded at	Director	MD ANNE ARUNDEL HANOVER			1 ☐ Yes 2 XNo
	with the	Dire	7606 POST ROAD	10f. Zip Code 21076	10g.	Citizen of What Country?
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - American Indian,
36	a 9	by Fu	1 □ Never Married 2√2 Married 1 ☑ Yes 2 □ No US	es, sp <i>eci</i> fy Cuban, Mexican, Puent ]Yes 2√2 No <i>Specify:</i>	o Rican, etc.)	Black, White, etc.  Specify: BLACK
215-0036	72 hours "natural", idical Exe	ted	15. Decedent's Education 16a. Deceden	it's Usual Occupation	16b.	. Kind of Business/Industry
	within 7 ane. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of wor NOT use retired) RACTOR	King	CONCEDUCATION
א ס	Hyginather Hyginather	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	CONSTRUCTION (en Sumame)
yland	nould be if Mental narked c	To B	ELLSWORTH MATTHEWS	HELEN	HEBRON	
Mar	d 2 st th and 7 is n traun			Address (Street and Number or Ru $POST$ ROAD, H		
	s 1 and if Health Itam 27 other ti		20a. Method of Disposition 20b. Place of Disposition			Location - City or Town, State
more	Pages ment of ant: If It ury or o				2/06 на	ANOVER, MD
Dall	permit. Page Depertment Important: If any injury o			ame and Address of Facility H		NERAL HOME 21207
				the mode of dying, such as cardiac		E, BALTIMORE, MD Approximate
	Physician		Immediate Cause (Final disease or condition	Gongopeth	3	Interval Between Onset and Death 2 4001
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	9600	do	
		Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	final	.70	
/	acuted ind transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C			
8/60,	icate be executed physicien and the burial-transit		Due to (or as a consequence of):			
٥		Medical	d.			
X D	death certifi e attending i id for use as	lan/N		topic pregnancy		23d. Date ol delivery  Month Day Year
	0 0 0	Physician/M	1   Yes 2   No 9   Unknown 4   Pregnant at time ol death 5   Ol 9   Unknown	ther (specify)		Monar Bay . Gai
ds, r	requires that the een signed by th hould be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the under	riving cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
000	w requires that been signed to should be det	eted	Themand hence	xisi	1 🗆 Yes	
Hec	The law ate has b page 2 st	Completed	Francis Publication		24a. Was an autopsy performed?	24b. Were autopsy lindings available prior to completion of cause of death?
Z	artiticat ctor, pi	Be C	25. Was case referred to medical gyaminer?	26. Place of Dea	th Check only one	No 1 ☐ Yes 2 XNo
<u> </u>	Physician: r this certitic ral director,	၉	1 No Hospital: 1 Inpatient 2 ER/Outpatient		ome 5 Residence	
	Attending In death.	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	llury occurred
UNISION	or Atter ter dea irector n by the	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
ב	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely tilled in by the tuneral director, page 2		29a Certifier Certifying Physician: To the best of my knowledge, death or	coursed at the time, date and place	and due to the equip	(a) and manner or stated
	he Hos in 24 h he Fur pietely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	tigation, in my opinion, death occur	rred at the time, date a	and place, and due to the cause(s)
	with To t	Σ	29b. Signature distribution certifier ACVIII HOS	29c. License number	29d. [	Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print	nt)	Set	Calous Dune
	( '		Gurmest Sawhney, MD,	325 HogoHA	( AR. St.	0 202, MD 21061
	Sta Registr	_	31. Date filed (Month, Day, Yeār)  32. Registrār's Signature	50 % B		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bruce September 18 2006 10:22 A M Robert Nancarrow, Sr. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 3939 Sea Side Court, Apt. 205 North Beach Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, You Jan 27 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 7 1954 **Funeral** Days 1**X** M 2 □ F Hours Min. Colorado 212-66-6688 Director Usual Residence of Decedent deeth with the Maryland **₩**O**Ų** 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28e-f ebov other treumatic event, the Mudical Examir armustice notified at 1 ☐ Yes 2 No MD Calvert North Beach Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Sea Side Court, Apt. 205 20714 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Journeyman Plumber Mechanical Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Jean Armstrong Nancarrow James Nagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3939 Sea Side Court, Apt. 205 North Beach MD 20714 of Health item 27 Linda Jane Hill Nancarrow, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 (ment of ) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of important: if eny injury or once. 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 09-18-2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Listyn Rausch Funeral Home, PA Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anaplastic Cancer of the Left Leg Physician /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Metastatic Lung Disease that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Pathologic Fracture of Left Leg IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3√ Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□ No 1□ Yes 2⊠ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phye within 24 hours efter death.
To the Funerel Director: After this completely filled in by the funeral directors. 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) SEP 2 1 2006

Zafar Ansari, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7E Post Office Road, Waldorf, MD 20602

Division of Vital Records, P.O. Box 68760,

D0053219

September 18, 2006

			1 - For Registrar	State of Maryla	-	artment of Hertificate of E			iene a. No. 200	)6 2994(
	Physici		Decedent's Name (First, Middle, La     Baby Boy Obalua					2. Date of Deat Month	th Day Yea	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv		· · · -	4b. City, Town, or	Location of Death	* PICWIC	4c. County of De	eath
	Funeral		5. Social Security Number 6.5	AS HOSPHAL Sex 7. Age (In yrs	. last birthday)	Saltimo If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.1	Birthplace (State or Foreign
ļ.	Funeral Director		none	<b>™</b> 2□F	Yrs.	Months Days	Hours 10n.	B. Date of Birth (Month, Day, Sept 8,	Year) 2006 Ma	Country)
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	e Man Sa-f eh	ctor	MD Prince	George's L	aurel					1 ☐ Yes 2 XNo
	with th	Dire	10e. Street and Number			10f. Zip Code	20723	10	0g. Citizen of What USA	Country?
	death me 23	nera	9611 Dixon Lane 11. Marital Status	12. Was Decedent Ever in t	J.S. 13. )	Vas Decedent of His f Yes, specify Cuban		city Yes or No-	14. Race - Ar	merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23e or 28e-f show any injury or other traumatic event, the Madical Exaciding in use it inclined at once.	by Funeral Director	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		rYes, specify Cuban I□Yes 2[X]No	Specify:	Hican, etc.)	Black, W Specify: b	
Maryland 21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest gro		16a. Deced	lent's Usual Occupat	tion urina most of worki	na	16b. Kind of Busines	ss/Industry
121	within ene. then "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)				
<b>d</b> 2	if Hygi other	Be Co	17. Father's Name (First, Middle, Last	none	none		18. Mother's Name		lone Maiden Sumame)	
ylar	ould be Menta arked	To B	Joshua Obalua	191 27 201 1 202			0	lukemi C	)balua	
Mar	d2 sh th and t7 is m treum		19a. Informant's Name/Relationship ( Johns Hopkins Ho	• • • • • • • • • • • • • • • • • • • •		g Address (Street ar Wolfe Str			City or Town, State  1D 21287	e, Zip Code)
ē,	item 2		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place	D		20c. Location - City	or Town, State
Baltimore,	Page ment cant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 💢 Other (Special	y in state	-	atory or ourse place	,			
Ball	Depart Depart Import any in		21. Signature 1 runeral Sarvice Licenter 1	Wade Directo		Name and Address altimore,			Baltimore	e Street
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not ente	er the mode of dying	, such as cardiac o		est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Extrem		Premas	mity			2/3/7 Weeks
	Examiner		ſ	Due to (or as a conse	quence of):		ŕ			
	D 15	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):					
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8760,	ate be executed hysician and the burial-transit	cal		_ d						
9 X	certifica ding ph se as tl	/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancy					
Box	uires that the death certific signed by the attending p d be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feto 4 ☐ Pregnant at time of a 9 ☐ Unknown	el death 3 □	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
P.O.	that the ad by the detach	Phy	9 ☐ Unknown  Part II. Other significant conditions of	121111	sulting in the un	ideriving cause giver	n in Part I	23e Did tob	acco use contribute	to the cause of death?
Records,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	ed by			, and a	acity ing cause given				Probably 4 Unknown
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tal	an: Th tificate or, pag	a	25. Was case referred to medical				26. Place of Death		1 □ Y	es 210 No
Ž	hysici his cer I direci	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatien	Othor	~	223	nce 6 ☐Other (Sp	pecify)
o uc	ding P		27. Many of Death 1 Whatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 7	,	8d. Describe how	w injury occurred	
Division of Vital	Attending or death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injury - At h	ome, farm, stre		es 2 No	8f. Location (Str	eet and Number or	Rural Route Number,
۵	oital or A urs after orel Direc		4   Homicide	building, etc. (Speci				City or Town,		
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: Atter this certificate ha complataly filled in by the funeral director, page	Medicai	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Exar	nysician: To the best of my known or the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my opii	e, date and place, a nion, death occurre	nd due to the car d at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complate	Σ	29b. Signature and title of certifier	2		29c. License		9	d. Date signed (Mo	A .
7			30. Name and address of person who	Completed cause of death (Item	m 23a) (Tune 1		52050	5	effember	4, 2006
			Brenda Ros	S,MD 60	O N. U		reet B	Alternora	e, MANIA	9, 2006 and 21287
5	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 20	32?Registrar's Sign	ature /	4			,	
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State of Maryland / Department of Health and Mental Hygiene? 29941 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year EMMA GRACE PALAT SEP 2006 17 7:27 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 13,2006 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕶 F Days 4 Hours Director N/A Yrs. Maryland Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 Items 23a 8009 Pine Ridge Road 21122 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) Dependent Dependent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas J. Palat Melissa Blatt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 I Nicholas J. Palat (Father) 8009 Pine Ridge Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem 9/25/06 Arlington Virginia 21. Signature of Fungral Service Licensee <sup>22. Name and Address of Facility</sup> McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ANENCEPHALY /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consumence of) anding physicien and use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. F ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ate has been signe page 2 should be 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2♥ No 24a. Was an autopsy performed? 1 Yes 2 😾 No Hospital or Attending Physician: After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101236794 (VA) K ause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER ĻΤ MC USN CHRISTOPHER M. WATSON BETHESDA MD 20889-5600

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 1 2006

gistrar's Signature

			1 - For State Registrar	State of Maryla	-		nt of H		Mental H		2000	2001	. 2
			Decedent's Name (First, Middle, La	st)		7111100	10 01 1		2. Date of E	Reg. No eath	.2000	3. Time of Death	<u> </u>
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1	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City	, Town, or	Location of Dea			. County of Death		
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	inyland show		Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo	_ A	1.11					10d. Inside City Lim	
	death with the Maryland rms 23a or 28a-f ehow rmat be notified at	Funeral Director	10e. Street and Number	more N	inds		ip Code			10g. Cit	izen of What Co	1 ☐ Yes 2 v	10
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23s or 28s-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		was Dec If Yes, sp		spanic Origin? ( i, Mexican, Pue Specify:	Specify Yes or N no Rican, etc.)	10-	14. Race - Amer Black, White Specify:		
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o.	es that the death certif igned by the attending be deteched for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ŒNo 9 □ Unknown	4☐Pregnant at time of 9☐Unknown		Other (s					Month	Day Year	
<u>α</u>	The law requires that the death certify he seems signed by the attending age? should be deteched for use as	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying	cause give	n in Part I.				the cause of death?	
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ð	Phys this ral dir	<u>2</u>	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of			4 🗆 Nursing	Home 5 ☐ Res		6 □Other (Spec	fy)	
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	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medicai C	29a. Certifier 1 Certifying Ph (Check only one)	nysicien: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death nation and/or in	h occurred vestigatio	d at the time n, in my opi	e, date and place nion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as	stated. o the cause(s)	
	Vithir To th comp	Me	29b. Signature and title of certifier			29	c. License	number		29d. Dat	e signed (Month,	Day, Year)	
			Danton (	Mga.			D	00597	36	Au	femker 1	8 2006	
	3		30. Name and address of person who	completed cause of death (Ite	am 23a) (Type,	Print)			1	1	·		
			DEBURAH WATS		MORTHW	E 57	HOSPA	1 5	401 04	0 00	URT RO	AD	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	iature	host	U						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 12, 2006 6:09 AM M Robert Oscar Pasterfield Jr /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Manor Care Ruxton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Yrs. 81 Director Maryland 219-18-9088 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28e-f show other treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road 21093 Funeral 12. Was Decedent Ever in U.S. A med Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 142-45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 job analyst BGE utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H item 27 is marked otl Robert Oscar Pasterfield Sr Marth May Donohue 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan P. Bourne/daughter P.O. Box 16 Monkton, MD 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State 21. Signature Funeral Service Licensee Konald S. Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Deat 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury Directo (or se a consequence of) Examine requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**27** No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifications. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Cther: 4 ursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerei D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title? 0012849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 6:55P DORIS C PARKER 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF 217-26-2650 Director 74 05/20/1932 N. CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified a MD N/ABALTIMORE CITY XXYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 5521 NORWOOD AVENUE 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED SELF-EMPLOYED permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygies Important: If item 27 is marked other the eny injury or other traumatic event, that once. 9TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN JULIE STEVENSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM L PARKER / HUSBAND 5521 NORWOOD AVE., BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 9/20/06 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Enter the disease, or complications that caused the diath. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final dise or condition resulting in death) Physician year /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown ت Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ UMG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 Sil 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17/2006 D25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Charles Street/Balfimore MD 21204 lendall R raulener MD 6601 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature. State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10e per fb 9860 10-3-06 vt
State of Mayland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marytan	d / Depa Cei	irtment <i>tificate</i>	of Health of Deat	i and M h	ental Hyo	giene Reg. No.	200	6	2994
	Dharaini		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ath Day	. Voos		Time of Death
Н	Physici /Medio		Bernadette Virgini	ia Rogers					Sept.	20 ay	2006		:35 A M
j	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, T	own, or Locatio	n of Death		4c.	County of Dea	ath	
			Brighton Gardens			To	wson				Baltimo	re	
	Funeral		5. Social Security Number 6. Sex		**		Year If Und Days Hours		8. Date of Birt	h			(State or Foreign
	Director		214-18-5383	M 2□ F 83	Yrs.		,,		Feb. 15	19	23 N	(D)	
	pur ≱_		Usual Residence of Decedent  10a, State 10b, County	10c Cih	, Town or Lo	cation						104 1	nside City Limits
	Aaryli Febo	ō	MD Baltimo		owson								Yes 2√ No
	28a-	ect		N. Charles St		10f. Zip (	Pode .			10a Citi	zen of What C		X
	with Sa or		8101 Bellona Ave.	N. Charles of	•	101. Z.p.	21204			rog. Oiti	USA	ountry	
	ne 23	era		2. Was Decedent Ever in U.	S. 13. V	Vas Decede		Origin? (Spe	city Yes or No-		14. Race - Am	erican Ir	ndian
21215-0036	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other then "natural", or iteme 23a or 28a-f ehow event, I'm Madical Exart as trival be natilised at	by Funeral Director	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		fYes, specif I∐Yes 24	_		cify Yes or No- Rican, etc.)		Black, Whi		
Ş	2 hor	Completed	15. Decedent's Educ		16a. Deced	lent's Usual	Occupation			16b. Kii	nd of Business	/Industr	у
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2	d will	E O	12	n/a	Schoo	ol Sec	retary			Ec	ducatio	n	
פ	oth vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name	(First, Middle,	Maiden	Sumame)		
<u>ā</u>		Tof	William Arndt					Irene	Bentz				
Maryland	d 2 should th and Mer ?7 is marke traumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (	Street and Nurr	nber or Rura	l Route Numbe	r, City o	r Town, State,	Zip Cod	θ)
	and 2 ealth n 27 i		Carol Zimmerman/dau	ighter	7 Jac	ckson	Manor (	Ct., P	hoenix,	MD	21131		
S S	of H		20a. Method of Disposition	^4	lace of Dispo	sition (Name	e of er place)	D	ate	20c. Lo	cation - City or	Town,	State
altimore,	Pages nent of ent: If it		1   Burial 2 □ Cremation 3 □ Re  □ Donation 5 □ Other (Specify)		id Ridg	ge Cem	etery	9/25	/06	Pil	kesvill	e, M	Ð
Balt	permit. Page Department Importent: It eny injury o		21. Signature of Funeral Service License MIChael J. Flag	le	]	Lemmon	Address of Factorial Funera	al Hom	e of Du imonium	lane	y Vall	ey,	Inc.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	n. Do not ente	er the mode	of dying, such	as cardiac o	r respiratory ari	rest,	721033	App	proximate erval Between
	Physician		Immediate Cause (Final	( smol ( ca)	trans	0 6	Temo	atio	,				set and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	6-2	100.00	1111	/			J	011
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٥	ntifica ng ph as th	Jed	IC CCIAN C									1	
X Q R	at the death certifis I by the ettending p steched for use as	Physician/Me	23b. was decedent pregnant	Bc. If yes, outcome of pregnar		Ectopic pred	nancy			2	3d. Date of de	_	
	dea ne ett	sici	in the past t2 fronths?  1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown		Other (spec					Month	Day	Year
J.	at the	h	9 ☐ Unknown ¹										
Kecords, I	signed	by	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	iderlying cau	use given in Par	rt I.	23e. Did to 1 □ Y	40	se contribute t 2No 3□P		use of death?
ပ္က	e law requ has been je 2 shouk	Completed							24a. Was a		24b. Were a	utopsy fi	indings available
	0 - 0	E							autop: perfor	med? 2 MNo	death?	complet	
VITAI	ilcien: Th certificete rector, pag	0	25. Was case referred to medical				26. Pla	ice of Death	(Check only or	/ 4	10.	, 2	
>	× S D	To B	examiner? 1 ☐ Yes 2 No	ospital:	ER/Outpatien	3 □ DOA	Other: 4 🗆 I	Nursing Hon	ne 5 ☐ Resid	ence 6	Other (Spe	ecity)A-S	sured living
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DIVISION	or Atten efter deat Director: I in by the	ii Ei	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory,	office	2	8f. Location (S City or Tow			ural Rou	ite Number,
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	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	ledicai	29a. Certifier (Check only one)  Certifying Physical Cartifying Physical Examination (Check only one)	icien: To the best of my know er: On the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at estigation, in	the time, date n my opinion, d	and place, a eath occurre	and due to the co	ause(s) ate and	and manner a place, and du	s stated.	cause(s)
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	7		XULTAI	Cun		T	2 S S S	503		Ser	rund	w o	70 400G
	10		30. Name and address of person who con	mpleted cause of death (Item		Pript)							20 2006 204
_ /			AMON Charle	, NO 6601		Cho	ves?	+ VS	ALTIN	NO	NO	212	Loc.
ı	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Park a							

			1 - For State Registrar	State of Marylar		nent of Heal		ental Hygier Reg. I	2000	29946
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	les V	Ric	hard		2. Date of Death	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give str	hallt.	410	City, Town, or Loca	tun	ne	4c. County of Death	A
	Funeral Director		5. Social Security Number  6. Sex  121  Usual Residence of Decedent	7. Age (In yrs.			urs Min.	3. Date of Birth (Month, Day, Yea May 24, 1	Cou	place (State or Foreign ntry) ary and
	with the Maryland is or 28s-f show	ctor	10a. State 10b. County N/A	10c. Cit	ty, Town or Location	Salle	me	ا		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	s 23a or 26 sust be no	Funeral Director	10e. Street and Number 911 Le a den	hall It.	410	of. Zip Code	230		Citizen of What Cou	SA
5-0036	72 hours after death natural', or Items 23 dical Examiliani usi	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of Hispani , specify Cuban, Me res 2 No Spe	ic Origin? (Spec exican, Puerto Ri	ity Yes or No- can, etc.)	14. Race - Ameri Black, White Specify:	
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Maryland	buld be filed Mental Hygid arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last)	chardson	)	18. N	Mother's Name (	First, Middle, Maid	en Sumame)	R
	permit. Pages 1 and 2 should be filed within Department of Health and Menial Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm Monce.		19a Informant's Name/Relationship (Type Re O be Richard 20a. Method of Disposition	San-broine	19b. Mailing Ad	S. Pac	umber or Rural a St.	Ball	or Town, State, Zij	21230
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ⊠ Burial 2 □ Cremation 3 □ Rer  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	moval from State	ouns Il	y or other place)  Q  Ve  ne and Address of F	9-22	-06 C1	000 ( )	le mo.
Ba	permi Depar Impo any ir		23a. Pant enter the disease, or complica shock, or hear failure. List only one	my	Gar	ug P. N	rarch	O Fred H funeral	/-/	Bacto nd
P	Pnysician /Medical		shock, or heart failure. List only one Immediate Cadse (Final disease or addition resulting in death)	Due to (J as a conseq	ial Infa	arction				Interval Between Onset and Death IVn mediate
Ļ	cate be executed XX physician and XX III it is burial-transit E	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	Artery Lence of):	Disease				10 years
		ın/Medical	230. Was decedent pregnant	:. If yes, outcome of pregna 1□Live birth 2□Feta		pic pregnancy			23d. Date of deliv	•
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Records, I	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions contri	ibuting to death but not res	ulting in the underly	ring cause given in F	Part I.	23e. Did tobacco	o use contribute to t	he cause of death?  pably 4 □Unknown
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of Vital	Physician: this certifica al director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[	Othor		Check only one)	6 □Other (Special	
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fa	actory, office	28	f. Location (Street City or Town, Sta	and Number or Rura te)	al Route Number,
	he Hospi in 24 hour he Funeri pletely fille	Medical (	29a. Certifier (Check only one) 1	cian: To the best of my kno r: On the basis of examina and manner stated.	wledge, death occu tion and/or investig	urred at the time, dat ation, in my opinion,	te and place, an , death occurred	d due to the cause at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
	To t To t	×	29b. Signature and title of certifier  Showlablus			29c. License numl			Pate signed (Month, 9/21/06	* * *
1	3		30. Name and address of person who com Sandra Marshall	pleted cause of death (Item	n 23a) (Type, Print)	J. Green	e Street	Baltin	9/21/06 ore, MD	21201
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 200	32. Registrar's Signa	iture	The I			,	

		1 - For State Registrar	State of M	aryland		artment rtificate			nd Me		ene g. No. 20	06 2	994
Physici	an	1. Decedent's Name (First, Middle							2	Date of Deati		3. Tin	ne of Death
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Funeral		5. Social Security Number		e (In yrs. las	st birthday)	If Under 1		If Under 2 Hours	24 Hrs. 8 Min.	. Date of Birth (Month, Day,	Year) 9.	Birthplace (St.	ate or Foreign
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land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation						10d. Insid	le City Limits
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If it is 15-15-15-15-15-15-15-15-15-15-15-15-15-1	Funeral Director	10e. Street and Number				10f. Zip C	ode			10	g. Citizen of Wha	t Country?	
23a c	alD	1236 Oakland Te	errace Road				21	1227			US.	A	
er dez	nue	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decede	nt of Hisp y Cuban,	anic Orig Mexican,	jin? (Specif , Puerto Ric	y Yes or No- can, etc.)		American India Vhite, etc.	n,
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should nd Mer n marks	၉	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	na Address (	Street and	d Number		sta Rus Bou <i>te Number</i>	City or Town, Sta.	te. Zin Code)	
nd 2 salth ar		Johns Hopkins								ltimore		287	
Pages 1 and nent of Health nt: If Itsm 27 iry or other tr		20a. Method of Disposition	_	20b. Plac	ce of Dispo	sition (Name	of er place)	i	Date	9 2	Oc. Location - City	or Town, Stat	е
Page ment ant: H		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (S	pecify) in state	- 1		,		ļ					
Definition of your yield of 12 12 12 12 12 12 12 12 12 12 12 12 12		21. Signature of Euneral Service	S. Wade, Dir	ector	The second secon	ate Analysis			at the first of the second		Baltimor	e Stree	et
1100		23a. Part1. Ent r the disease, of shock, or heart failure. List	complications that caused	d the death.							st,	Approx	imate Between
Physician		Immediate Cause (Final disease or condition	MuHist	. 0	mben	ital	An	AMA	Hies				and Death
/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):								
	er	Sequentially list conditions, if any, leeding to immediate	b	a conseque	nce of):								
uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>										
be executed sicien and burial-transit		resulting in death) Last	Due to (or as	a conseque	nce of):								
ate be shysicii the bu	Physician/Medical		d										
The law requires that the death certificate site has been signed by the attending phys page 2 should be detached for use as the	Med	IF FEMALE:	22- 14										
eath certific attending p	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	eath 3	Ectopic pred					23d. Date of Month	delivery Day	Year
that the de ed by the detached	ysk	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	( IIII oi dea	(ii 3 )	J Other (spec	.ny)						
res that igned b	by Pł	Part II. Other significant condition	ons contributing to death b	ut not resulti	ing in the u	nderlying cau	se given	in Part I.		23e. Did tob	acco use contribut	e to the cause	of death?
v require been sig should b										1 ☐ Ye	s 2.⊡No 3.⊡	Probably 4	Unknown
he law re	Completed									24a. Was an autopsy	24b. Were	autopsy findi to completion	ngs available
	Con									perform	ed? deat	h?	
sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Title Court Court				7			Check only one	-		
Phys rathis	2	1 Yes 2 No	1 Linpation 1 28a. Date of Inju		NOutpatien  8b. Time of			4   1401			nce 6 □Other (S winjury occurred	Specify)	
ding f th. : After s funer	tion	1 ☐ Matural 5 ☐ Pendin 2 ☐ Accident investi	g (Month, Da	y Year)	Injury	м	Work?	s 2 □ N			in injury occurred		
Attar ector by the	Certification;	3 Suicide 6 Could of determined	ined 288. Place of In	ury - At hom c. (Specify)	e, farm, str	eet, factory,	office		28f	Location (Str City or Town,	eet and Number o.	Rural Route	Vumber,
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To the Hospitel or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certified completely filled in by the funeral director.	edical	29a. Certifier 1 Check only 2 Medical	g Physician: To the best Examiner: On the basis o and manner st	f examination	edge, death n and/or in	n occurred at vestigation, in	the time, n my opin	date and ion, death	f place, and h occurred	d due to the ca at the time, da	use(s) and manne te and place, and	r as stated. due to the cau	se(s)
To the To the comp	Me	29b. Signature and title of certifie	MINA		1	29c. I	License n	umber		29	d. Date signed (M	onth, Day, Yea	ar)
		Veris	a may	107	LA	) R	35-	00		S	eptember	- 7.20	206
		30. Name and address of person	who completed cause of o	leath (Item 2	3a) (Type,	Print) X (	1 1) 4	10-	CI	Bo 11	o Date signed in Eptember More, MA	1/2 /	26217
Sta	te	31. Date filed (Month, Day, Year)	38. Registr	ar's Signatur	6 00	14.	V 0	11-6	J1 '	1914 [11	MORE, IVIAL	YHANC-	11481
Registr		SEP 2 1 7	2006 Serve	, K	1500	N. S.							

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of Maryla		irtment of tificate of			giene Reg. No.	2006	29948
महित्र ,	Physici /Medic Examin	al	1. Decident's Name (First, Middle, Last  HLICE  4a. Facility Name (If not institution, give	street and number)	ANOS	4b. City, Town,	or Location of Deat	2. Date of De Month	2 ( 4c. 0	Zerv County of Death	
D	uneral irector		Usuel Residence of Decedent	7. Age (In you	s. last birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Bir (Month, Da Oct. 4	th av. Year)	.4   Ohic	place (State or Foreign ntry) )
with the Marylar	s or 28a-f show Le notified at	Funeral Director	MD Anne Arur  10e. Street and Number	ndel Se	verna P	ark 10f. Zip Code			10g. Citiz	en of What Cou	10d, Inside City Limits 1 ☐ Yes 2 🔯 No ntry?
1215-0036 within 72 hours after death with the Maryland	rai', or items 23a or 28a-1 show Examinat must be notified at	þ	24 Windward Driv  11. Marital Status  1 Never Married 2 Married  32 Widowed 4 Divorced	7C  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		21146 Vas Decedent of Yes, specify Cu  ☐ Yes 2☐XN		pecify Yes or No o Rican, etc.)		USA  4. Race - Ameri Black, White,  Specify: Whi	, etc.
N	natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)		(Give	OO NOT use reti	e during most of wo red)	rking me (First, Middle	Self	f of Business/In	
larylan 2 should be	I neath and wental rigglene. itam 27 is marked other than other traumatic event, to M	To Be	Carl Winter  19a. Informant's Name/Relationship (7)		1		Nellie et and Number or Ri	Handler ural Route Numb	er, City or	Town, State, Zij	,
more,	nt: if		Ellen E. Eckert -  20a. Method of Disposition  1 Burial 2 Cremation 3 4  Donation 5 Other (Specify,	Removal from State	Place of Disposicemetery, crem	sition (Name of natory or other p ematory	Sep	Date 22. 06	20c. Loc	ation - City or To	own, State
Ba	importa any inju		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compshock, or heart failure. List only o	Oloce lications that caused the de			ress of Facility 1 Society 2 rick Roac ying such as cardia			Inc MD 2122	Approximate Interval Between
//	ysician Medical aminer	_	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consi	her h	vers	Wenne	Ain			Onset and Death Gylun
Box 68760, Codeath certificate be executed	hysician and the burial-transit	ical Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect  d.							
P.O. Box 68 nat the death certifica	by the attending pached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnan Other (specify)	icy	20-m-11-4	23	3d. Date of deliv	ery Day Year
Records, P.O The law requires that the	been signed t should be det	þ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the un	nderlying cause o	given in Part I.		obacco us Yes 2□	No 3 ☐ Prot	
	nis certificate has t director, page 2 s	Be Completed	25. Was case referred to medical examiner?				26. Place of De	24a. Was auto perfo  1 Yes  ath (Check only of	psy ormed? 2 LV No	24b. Were autoprior to codeath? 1  Yes	opsy findings available ompletion of cause of 20 No
n of	fter this ineral di	Certification: To E	1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W	ury at ork? □ Yes 2 □ No	ome 5 Resi 28d. Describe	how injury	occurred	
	within 24 hours arier deam.  To the Funeral Director: A completely filled in by the fu		4 Homicide determined  29a. Certifier 1 Cartifying Phy	28e. Place of Injury - At building, etc. (Special Sician: To the best of my k	cify)nowledge, death	occurred at the	time, date and place	City or To	wn, State)	and manner as s	al Route Number,
To the Hospital o	To the Fu	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	ner: On the basis of examinand manpres stated.	nation and/or inv	29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)
	Z Sta	to	30. Name and address of person oc MICHAR 31. Date filed (Month, Day, Year)	om let d cause of death (It	7 41	Print) D	EFENSI	= Ana	HWA	ty Ann	21,200C VAPOLOM D
	Regist		SEP 2 1 200	W	Si April	de					

			1 - For State Registrar	State of Maryland	d / Departn		ealth and I	Mental Hy	giene Reg. No. 200	6 29949
8 4	Physici		Decedent's Name (First, Middle, Las		MAE SHO			2. Date of De Month		3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, gives SAINT AGNE 5. Social Security Number 212–38–0615	ES HOSPIT	AL (	City, Town, or L  ALT  Under 1 Year  nths Days	ocation of Death  If Under 24 Hrs. Hours Min.		4c. County of De. N/A	
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A	10c. City	, Town or Locatio	n timore				10d. Inside City Limits 1 🖫 Yes 2 □ No
	h with the 13a or 28 at be no	al Director	10e. Street and Number 3201	Wilkens Avenue	2	of. Zip Code	21	229	10g. Citizen of What C	country?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show sty injury or other traumatic event, in a Medical Examinar must be neithful an ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Decedent of His , specify Cuban /es 2 2 No	panic Origin? (Sp., Mexican, Puerlo Specify:	Decify Yes or No Decify Yes or No Decify Yes	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 ho iene. 'then "natui ine Medicel	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		16a. Decedent's (Give kind life. DO N	Usual Occupat of work done du IOT use retired)  Homema	uring most of wor	king	16b. Kind of Busines:	
Maryland 2	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last)	Charles Gar	rison		18. Mother's Nam	ne (First, Middle, yn Edmo	Maiden Sumame)	LIC
	is 1 and 2 should of Health and Men item 27 le marke other traumatic		19a. Informant's Name/Relationship (7) Joseph C. Shorb	(Son)		Charles	s St., B			201
Baltimore,	permit. Pages Department of Pimportant: If its eny injury or of once.		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify  21. Signatur of Fun re Service Licen	Removal from State Bay	emetery, cremator view Crei	y`or other place; matory,	Inc. 9/	21/06	Baltimore,	Maryland
Ba	Depa Impo eny ii		23a. Part1. Enter the disease, or comp	——————————————————————————————————————	ker McC 130	ully-Po E. For	lyniak F t Ave.,	uneral Baltimo:	Home, P.A. re, Md. 2	21230 Approximate
2,092	Physician /Medical Examiner be overnied but sicieu and physicieu and phy	licai Examiner	shock, or heart failure. List only of disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	RDIAL  Jence of):  EXA  Jence of):	E CEBR		IDN	CER LUNG	Interval Between Onset and Death  A A A A A A A A A A A A A A A A A A A
P.O. Box 68	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 ☐ Ecto	pic pregnancy er (specify)			23d. Date of de Month	blivery Day Year
ords, P	equires that ien signed b ould be deta	by	Part II. Other significant conditions of	NSIDN				16	obacco use contribute	to the cause of death?
al Reco	as s	Completed	-Tosus)	XSTEMIC L	UPUS	ERXTH	+ROMA	perfo	prior to death?	utopsy findings available completion of cause of s 212 No
Division of Vital Records,	ding Phy n. After this funeral o	ation: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3[ 28b. Time of Injury	DOA Other	at Nursing n	ome 5 🗆 Resid	dence 6 Other (Spanow injury occurred	ecify)
Divis	ital or Attenders selter deetl rs efter deetl al Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, street, fa	actory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	dural Route Number.
	To the Hospital or A within 24 hours efter to the Funeral Directornpletely filled in by	edical	29a. Certifier 1 Certifying Physical Examone)	ysician: To the best of my know iner: On the basis of examinate and manner stated.	vledge, death occi ion and/or investig	urred at the time jation, in my opir	n, date and place, nion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To t To t com	Σ	29b. Signature and title of certifier  Macin,	M.D .		29c. License i			SEPT, 20,	th, Day, Year)
	10		30. Name and address of person who of MULHAMMAN	completed cause of death (Item	23a) (Type, Print)	J AVE,	BALTI	MORE	SEPT, 20,	229.
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 1 2	- 3	it spen	les				

SHORB, GEORGIA M

06-06846 Donald Seager

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 29950 Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) Physician/ Date of Death Medical Examiner 0425 hrs September 11, 2006 Donald Seager 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 3700 Greenspring Avenue Baltimore 5 Social Security Number If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Days Months Hours Director 1X M 2 Oct. 28, 1948 Country) Yrs Maryland <u>unknown</u> Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No is 23a or 28a-f show e notified at once. 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene and the first and 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once other traumatic event, the Medical Examiner must be notified at once Baltimore City MD Director 10g. Citizen of What Country 10e. Street and Number 3700 Greenspring avenue 21211 United States Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married Yes 2 X No if Yes, Give Year White Yes 2 X No specify: Widowed Divorced Specify ģ or Dates 16a Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Dependent Not Self Supporting 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert Frederick Seager Harriet Leader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 1123 Fairview Court, Silver Spring, MD 20910 David Seager, Brother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Pages 1 crematory or other place) Burial 2  $\mathbf{X}$  Cremation 3  $\mathbf{X}$  Removal from State Important: I 09/25/06 Rose Hill Cemetery Altoona, Pennsylvania Donation, 5 Other Specify Sturge Funeral Service Licensee 22. Name and Address of Facility Harman Funeral Service, P.A. 7221 Grayburn Drive, Glen Burnie, MD 21061 M01113 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Multiple injuries Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): Examine (Disease of Injury that Hit atea events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED item#23a.27.28a-f.perME\_0850\_0/22/06\_TP attending phys or use as the bu IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed

Division of Vital Records, P.O. Box 68760, seen s has certificate To the Hospital or Attending Physician: After this 24 hours after death Fo the Funeral Director: completely filled in by the

Be

Certification:

Medical

one)

27 Manner of Death

Natural

31. Date filed (Month, Day, Year)

SEP 2 1

25. Was case referred to medical	
examiner?	Hospital 1

Fnd 9/11/2006 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

Pending

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie

Inpatient 2

28a. Date of Injury

29c License number O.C.M.E

28c. Injury at Work?

1 Yes 2 No

29d Date signed (Month Day Year) September 11, 2006

death?

Residence 6 V Other Scene

subject precipitated from balcony 28f. Location (Street and Number or Rural Route Number, City Baltimore, MD700 Greenspring Avenue

1 🗸 Yes

24b Were autopsy findings available

prior to completion of cause of

2 Νo

24a. Was an

✓ Yes 2

Baltimore,

Nursing Home 5

autopsy

performed?

28d Describe how injury occurred

30. Name and address of person who complet cause of death (Item 23a)

Theodore M. King, Jr., MD. Assistant Medical Examiner 2006

111 Penn Street, Baltimore, MD 21201

26 Place of Death (Check only one)

State

residence

ER/Outpatient 3

28b Time of Injury

Fnd 4:23 am

		ı	1 - For State Registrar	State of Ma	aryland	•	rtment of F			giene 20	06	2995
	Physici	an	1. Decedent's Name (First, Middle, Last)			- '	· · · · · · · · · · · · · · · · · · ·		2. Date of Dea Month		(ear	3. Time of Death
	/Medic Examin	al	Bertha  4a, Facility Name (If not institution, give in the second of the	street and number)	Himo	Smith		r Location of Death	September	4c. County of	Death	11. 22#*
Ž.	Funeral Director		5. Social Security Number 6. Security Number 213–26–5181	-0-	e (In yrs. last 79	t birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 1-28-	, Year)	9. Birthpla Country	ice (State or Foreign y) Md.
erth	Maryland a-f ahow	tor	10a. State 10b. County NA		10c. City, T	own or Loc Balti					100	d. Inside City Limits 1   Yes 2   No
2	death with the ms 23e or 28e revet be not	Director	10e. Street and Number				10f. Zip Code			log. Citizen of Wh	at Country	y?
$\mathfrak{C}$	s 23a	era!	1824 Harford Ave	Was Decedent I	Francia II S	40.14	2121			US 14. Race		a ladia.
mith, 5-0036	io # #	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2XN If Yes, Give Year or Dates:			Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puerto Specify:	o Rican, etc.)	Black,	White, et	tc.
Smith	n 72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation	1	(Give k	ent's Usual Occup ind of work done O NOT use retired	during most of won	king	16b. Kind of Busi	ness/Indu	stry
	ed with rgiene er the	Com	8th grade	College (1940) 3	,*,	Hon	nemaker			Own Hom		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than surmatic event, the Man	To Be	17. Father's Name (First, Middle, Last)  Clayton		Johr	nson		18. Mother's Nam		Maiden Surname) John		
	2 shoul and Mi is marl sumati	F	19a. Informant's Name/Relationship (Ty	•		19b. Mailing		and Number or Ru	ral Route Numbe	r, City or Town, St	ate, Zip C	ode)
3 9	1 and Health em 27 ther tr	15	Diane Parker  20a. Method of Disposition	Daughte	20b. Plac	e of Dispos	ition (Name of		Date	20c. Location - C	:1213 ity or Tow	n. State
knowr Baltimore.	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic avant, the Monee.		1√ Burta 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)			timore	Nat. Ce	∍m.   9-2	1-06	Baltimo	re, l	_
+ Bal	Depariment of the popular of the pop		21. Sgnaturi of Funeral Service License	Walte	ret	/ ]		North Ave	., Balti		. 2	1202
A	Physician		23a Parri . Enter the disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resoliting in death)	cations that caused ne cause on each lin	(2)	Do not ente	r the mode of dyir	g, such as cardiac	or respiratory and	est,	li li	Approximate nterval Between Onset and Death
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rds.	w requires that been signed t should be deta	ρ	Part II. Other significant conditions cor	tributing to death bu	ut not resultir	ng in the un	derlying cause giv	en in Part I.		bacco use contrib es 2 □ No 3	ute to the	V
Reco	Physician: The law re this certilicete hes bee ral director, page 2 sho	Completed	Gerebral Vaso	ular Ha	eider	+	<del></del>		24a. Was a autop perfor	med? de	or to comp ath?	sy findings available pletion of cause of
/ita	Physician: this certilional director,	Be	25. Was case referred to medical examiner?	1-1-1			101		th (Check only or			
Division of Vital Becords.	Attending Physic death. setor: After this coy the funeral dir	tlon: To	1 Yes 2 No Cartesian State of Death  Valuation State of Pending investigation	lospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	-	VOutpatient Bb. Time of Injury	3 DOA Oth  28c. Injur Wor  M	4   Nursing H		ence 6 Other ow injury occurred		
Divisi	To the Hospital or Attending F within 24 hours elter death. To the Funeral Director: Alter completely tilled in by the funer.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home c. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural F	Route Number,
	na Hospital 24 hours ne Funeral Metely tilled	edical	29a. Certifier (Check only one) Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occui	, and due to the c rred at the time, c	ause(s) and mann late and place, and	ner as stat d due to th	ed. he cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier		$\sim$		29c. Licens	e number		9d. Date signed (	Month, Da	ay, Year)
	4	1	30. Name and address of person who	mpleted cause of de	eath Atem 23	3a) (Tvne F	HOY	201	10	2016m D		1, 5000
==	1		MICH PUDDTE	NOU	>1n	lai t	Respite	of BAL	timore	<u> </u>		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1	2006 32. Regist	ar's Signature	"A ,	grade	_				

Please Type of	or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible

		1 - For State Registrer  1. Decedent's Name (First, Middle, Last)	State of Maryland		artment of F		Re 2. Date of Death	g. No. 200	6 299 S
Physicia /Medic Examin	al	Joseph S. Schweit  4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, o	Location of Death	Month Sept.	Day Year 19 2006 4c. County of Dea	10:30 P
uneral rector		Stella Maris Hospi 5. Social Security Number $104-16-7164$ $104-16-7164$ Usual Residence of Decedent		ast birthday) Yrs.	Timoni  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Baltimor   9. Bin   Co   1918   NY	T <b>e</b> thplace (State or Forei buntry)
Se-f ehow	ctor	MD 10b. County Baltimor		Timo	ocation onium				10d. Inside City Limit
e 23a or 21 Just be no	Funeral Director	10e. Street and Number  12261 Roundwood Rd	-			093		g. Citizen of What Co	
Important: If item 27 is marked other then "natural", or iteme 23s or 28e-f ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  ★□ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1∑IYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1☐ Yes 2∏ No	ispanic Origin? (Spin, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
then "natu he Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed)  College (1-4or 5+)	(Give lite.	DO NOT use retired	during most of work.	ing	6b. Kind of Business	•
rked other lic event, II	To Be Co	17. Father's Name (First, Middle, Last) Otto Harry Schweit		Banke	r	18. Mother's Name		·	Credit
n 27 is mar er traumat		19a. informant's Name/Relationship (Type Katherine Krieger/	oe, Print)	1			al Route Number,	City or Town, State, 2	Zip Code)
tant: If iten jury or oth		20a. Method of Disposition	emoval from State	ace of Dispo emetery, crer aney V	sition (Name of matory or other place alley Mer	9/23 norial Gar	Date 20	oc. Location - City or	
eny in		21. Signature of Fundamental Signature of Sig	gle	Le 10	W. Pador	eral Home	limonium,	ney Valley , MD 21093	, Inc.
been signed by the attending physicien and must be detached for use as the burial-transit and the burial-transit a	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate dause. Enter underthing Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ence of):					Onset and Death
y the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant al time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
en signed b	þ	Part II. Other significant conditions con	tributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.		acco use contribute to	the cause of death
is certificate has be director, page 2 sh	Completed						24a. Was an autopsy performe 1 ☐ Yes 2	prior to death?	itopsy findings avail completion of cause 2□ No
After th	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2X No H  27. Manner of Death  1X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	M 28c. Injun Work	or: 4 □ Nursing Ho or at c? Yes 2 □ No	28d. Describe how	ce 6 Other (Spe v injury occurred	
To the Funeral Director: completely filled in by the i		4 Homicide determined  29a. Certifier X Certifying Physics	28e. Place of Injury - At hor building, etc. (Specify, lician: To the best of my know	yleddia diaast	S occurred at the to	se ofate and niana	City or Town,	ordel and the second	other of
To the Fur completely	Medical	(Check only 2 Medical Examirone)  29b. Signature and title of certifier	er: On the basis of examinati and manner stated.	ion and/or in	29c. Licens	oinion, death occurr	ed at the time, dat	e and place, and due  d. Date signed (Mont.)	to the cause(s)
_/		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)				

			1 - For Amend item#4b, pe	State of M	aryland / De 21/06 TT	epartmei Certifica	nt of H	lealth ar Death	nd Mental Hyg	jiene <sub>leg. No.</sub> 20	06 29953
	Physici		1. Decedent's Name (First, Middle, Last, ELI SA BETH		STOTZ				2. Date of Dea Month		Year 8200 AM
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City	Town, or	Location of Ville		4c. County of	00
	Funeral Director		5. Social Security Number 6. Sec		ge (In yrs. last birtho	Months	r 1 Year Days	If Under 24 Hours	4 Hrs. 8. Date of Birth (Month, Day Oct. 26	Year)	9. Birthplace (State or Foreign Country) MD
	show	٥٢	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o						10d. Inside City Limits
	th the M or 28e-f	Directo	MD Baltimor  10e. Street and Number	e	Lutherv		p Code		1	log. Citizen of Wh	1 Yes 2 No
	23s	rai	2 Pickett Garth	10 146 - 0 - 1 - 1	5 110		210			USA	
036	72 hours after death with the Maryland Instural, or Items 23s or 28s-f show Lical Examinar must be notified at	by Funeral Director	11. Marital Status  1X Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates:	No	If Yes, spe		ispanic Origii in, Mexican, I Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Specify:	- American Indian, , White, etc. white
21215-0036		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		5+) (G	ecedent's Use live kind of w fe. DO NOT	ork done o	durina most c	of working	16b. Kind of Bus	
	Hygie other	a	17. Father's Name (First, Middle, Last)		n,	а		18. Mother's	s Name (First, Middle,	Maiden Sumame,	n/a
ylan	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Me	To B	William H. Stotz					Doris	E. Kruger		
	alth and 2 Sho		19a. Informant's Name/Relationship (Ty William H. Stotz/f						or Aural Route Number imonium, MD		tate, Zip Code)
Baltimore,	permit. Pages 1 and 2 Deportment of Health a Important: If Item 27 is eny injury or other tre		20a. Method of Disposition 1 Burial 25 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	20b. Place of Di cemetery, Metro Cr	crematory or	other plac	,		20c.Location - C	ity or Town, State
Balt	Depertition Depert		21. Signature of Funeral Service Licens		agle	22. Name a			lome of Dul	aney Val	ley, Inc.
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as	ne.	AN C		g, such as ca	ardiac or respiratory arr	est,	Approximate Interval Between Onset and Death G Months
κ 68760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and rail director, page 2 should be detached for use as the burial-transit	Medicai Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
P.O. Box	that the death certificated by the ettending placed for use as to	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death	3 Ectopic p 5 Other (s				23d. Date Month	•
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions cor	tributing to death b	out not resulting in th	e underlying	cause give	en in Part I.		2. 2	oute to the cause of death?
al Records,	: The law re cate has be page 2 sho	Completed by	•						24a. Was a autops perform	ned? pri	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital	sicien: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	ospital:	ent 2 ER/Outpa	**** 0 0	Othe		f Death (Check only on		
ion of	anding Physicien: The ath.  or: After this certificate has funeral director, page	ation: To	27. Manner of Death 1 Katural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da			28c. Injury Work	4 🗀 IVUIS		ow injury occurred	
Division	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: After Completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ury · At home, farm, c. (Specify)				City or Towr	1, State)	or Rural Route Number,
	Fo the Hospital within 24 hours of the Funeral Completely filled	Medical	29a Certifier (Check only one) Certifying Physical Examination (Check only one)	ner: On the basis o and manner st	f examination and/o	r investigation	i, in my op	oinion, death	place, and due to the ec occurred at the time, do	ate and place, an	d due to the cause(s)
	To t To t	2	29b. Signature and title of certifier  MBoyle M	10			c. License	number	2	9d. Date signed (	Month, Day, Year)
5			30. Name and address of person who co		death (Item 23a) (Ty	no Print)			St. Balt	more 1	ND 21205
	Sta Registr		31. Date filed (Month, Day, Year) 200	32. Registr	ar's Signature	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 22 per fh 9859 9-27-06 vt State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. Day Year **Physician** 1027 PM September 8,2006 /Medical 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Bon Sesome If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Months 1⊠M 2□F Hours Yrs Director 217-66-2988 Sept. 1, 1954 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f ehow the Modical Examiner must be notified at 1x Yes 2 □ No Be Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Dolphine Street 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, While, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) metal refinishing welder 12 none traumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Brenda Stubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Stubbs/uncle 720 N. Hilton St. Baltimore, MD 21229 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒ Other (Specify) in state netro 21. Signature of Femeral Service Licensee Ronald S. Wade 22. Name and Address of Facillancy Wallace 3500 State Anatomy Board 93 Wallace Franklin St. Part 1. Enter the disease, or complications that caused the death." Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) FRFARCT **Physician** 0 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Box 68760. Physician/Medicai IF FFMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Eclopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a id be detached for 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 4 HILIKNOWN 1 □ Yes 2 □ No. 3 Probably Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 No 2 116 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Pres 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 3 1.OA 1 Inpatient 2 ER/Outpatient this within 24 hours atter up...
To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Lertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ÷ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of per

31. Date filed (Month, Day,

2000

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NE

			1 - For State Registrar	State of M		partment of I ertificate of		d Mental Hygi	ene 200	6 29955
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Deatl Month	Day Ye	
	/Medic	al	William R. Turne			4h Cihi Tourn	or Location of De		er 19, 20	
	Examin	er	3 Brandywine Ros			North		atri	4c. County of D	
	Funeral		5. Social Security Number 6. S	ex, 7. Ag	e (In yrs. last birthda	y) If Under 1 Year	If Under 24 F	Irs. 8. Date of Birth	9	Birthplace (State or Foreign
	Director		168-30-6568	☐M 2□F	68 Yrs.	Months Days	Hours M	lin. (Month, Day, Jan. 9,		PA
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl. febo	ō	MD Cecil		North Eas	a+				1 ☐ Yes 2 No
	r 28e	Director	10e. Street and Number		NOT CIT Eas	10f. Zip Code		10	g. Citizen of What	Country?
	th with	alD	3 Brandywine Roa	ad		21901			USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No- ierto Rican, etc.)		merican Indian, /hite, etc.
36	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-f ehow the Madical Examinar must be notified a	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 ☐ If Yes, Give Year or Dates:	<sup>№</sup> 1955	1 ☐ Yes 2 No		rlad ka	Specify:	1
21215-0036	2 hou	led t	15. Decedent's Ed	lucation	16a. Dec	cedent's Usual Occu	pation	hite	6b. Kind of Busine	white ess/Industry
2	thin 7.	Completed	(Specify only highest gra	de completed) College (1-4or 5	life	ve kind of work done  . DO NOT use retire	during most of ed)	working		
7	ed wi	Con	Elementary/Secondary (0·12)		Exte	erminator			Pest Con	trol
and	ntal H	To Be	17. Father's Name (First, Middle, Last) William R. Turner					Name (First, Middle, M		
2	should nd Me mark matic	Ţ	19a. Informant's Name/Relationship		19b. Ma	ulling Address (Stree		K. Kemmer		e. Zip Code)
Z S	nd 2 alth ar 27 is r trau	1	Madelyne Ann Tur	•				rth East,	ores are areas	. ,, ,
Jre,	of Hez		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation 3 □		20b. Place of Dis	position (Name of rematory or other pla		Date 2	0c. Location - City	or Town, State
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specific		Metro Ci	ematory	Sep	. 19, 06 E	altimore	MD
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Propretate: for Items 23a or 28e-f show eny Injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen	Merk	0	Cremation 299 Frede	isséffacility Prick Ro	y of Maryl ad Baltimo	and, Inc	i228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do not e	enter the mode of dy	ng, such as card	fiac or respiratory arre	st,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)	aC	OPID					Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):	18				
-	1	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of):	nass				
1	outed nd nansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events	a	osh'c	abdon	harry	anus	yew.	
ő,	cate be executed physicien and the burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequence of):				đ	
8760,	cate b physic the b	dica	•	d						
Box 6	leath certifica attending ph	ı/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of	delivery
Ö.	s death ne atte ed for	Physician/Medical Examiner	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∏Pregnant at 9∐Unknown		3 □Ectopic pregnand 5 □ Other (specify) _	ey		Month	Day Year
P.O.	d by the	Phy	9 ☐ Unknown  Part II. Dther significant conditions of		ut not reculting in the	Lunderhing course a	uon in Part I	22e Did tob	acco uso contribut	e to the cause of death?
Division of Vital Records,	Attending Physician: The law requires that the death certificate be executed to death.  Tobath.  ector: Attenthis certificate hes been signed by the attending physicien and by the funeral director, page 2 should be deteched for use as the burial-transit	ted by	Tarris Build Significant Street, and a	ontributing to death o	at not resulting in the	ouridenying cause gr		1 Ø Ye		Probably 4 Unknown
ecc	hesbe pe 2 sh	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
E H	ician: The certificate I rector, pag							perform 1 ☐ Yes 2		
₹	siciar certif irecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2□ER/Outpat	inat all post of	hac	Death (Check only one		
o	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Inju		g Home 5 Resider		рресту)
Ö	adh. rath. r: After	atio	1 ■Natural 5 □ Pending 2 □ Accident investigation	1	y Year) Injur		]Yes 2 □No			
É	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	ury - At home, farm, c. <i>(Specify)</i>	street, factory, office		28f. Location (Str. City or Town,	eet and Number of State)	Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edical C	29a. Certifier 12 Certifying Ph (Check only one)	ysician: To the best niner: On the basis o and manner st	f examination and/or	ath occurred at the t investigation, in my	ime, date and pla opinion, death o	ace, and due to the ca ccurred at the time, da	use(s) and manner te and place, and	r as stated. due to the cause(s)
	To th Withir Comp	Me	29b. Signature and title of certifier	. 0 .	)		se number		d. Date signed (M	onth, Day, Year)
)			) (mal	reel		D00	2618	3 .	Sept. 1	9,2006
	341		30. Name and address of person who	completed cause of c	leath (Item 23a) (Typ	e, Print) Aue. 1	forTh ,	EAST, M.	2/901	
	Sta		31. Date filed (Month, Day Year) 1	2006 32. Registr	ar's Signature	Sparts 3		)		
	Registr	ar		1	and the	1				

06-06537 Jerome Taylor

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

onie rayioi		1- For State Conversion Certificate of Registrar			3. No. 200	6 2995
Physicia	an/	Decedent's Name (First, Middle,Last)	<u>-</u>	Date of Death     Month	Day Year	3. Time of Death
dical Exami	ner	Jerome Taylor	W 02 T	August 30,	2006	0955 hrs
Parks .		4a. Facility Name (if not institution, give street and number)  Mercy Hospital	4b. City, Town, or Location of I Baltimore	Death	4c. County of Death	_
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2	24Hrs. 8. Date of Birth	n(MM/DD/YYYY) 9. 8in	thplace (State or
Director		244-90-4980 1XM 2F 56 Yrs.  Usual Residence of Decedent	Months Days Hours	May 1,		<sub>n</sub> North <sup>untry)</sup> Carolina
any		10a. State 10b. County 10c. City, Town or Locati	on			10d. Inside City Limits
and show nce.	ō	MD Baltimor	e			1 Yes 2 No
Maryl 28a-1	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Cour	ntry?
with the Maryland ms 23a or 28a-f show be notified at once.		3017 The Alameda	21218		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f sho ratic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces?	s Decedent of Hispanic Origin es, specify Cuban, Mexican, P		14. Race - Ameri White, etc.	can Indian, 8lack,
fter de		3 Widowed 4 Divorced If Yes 2 No	Yes 2 X No specify:		Specify: bla	ıck
ours a atura xamin	d by		t's Usual Occupation (Give kir ost of working life. DO NOT us		16b. Kind of Business/I	ndustry
n 72 h an "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	· ·	se retired)	1	
OO3	mo	12 0 carpe		Name (First, Middle, M	home impro	vements
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.	Be	Albert Lutz		elia Taylo	- ,	
2121 ould be f Mental s market ic event,	ToE	19a. Informant's Name/Relationship (Type, Print )	Address (Street and Number	er or Rural Route Numb	per, City or Town, State	, Zip Code)
<b>₹</b> 2 ± 2 <b>■</b>			The Alameda B			
ore, Nest tand of Health If item		20a. Method of Disposition  1 8urial 2 Cremation 3 Removal from State crematory or oth	ition (Name of cemetery, ner place)	Date	20c. Location - City or	Town, State
Page ment of		4 Donation 5 X Other Specify: in state				
Baltimore, permit Pages Lanc Department of Heal Important: If item injury or other tra		21 Streture of Typer Service Licenses Director 28 L	ate Anatomy Bo	oard 655 W.	. Baltimore	Street
Physician	/	23a. Lart I. Enter the Leas of r completions that caused the death. Do not enter the	1timore. MD 2 ne mode of dying, such as card	21201 diac or respiratory arres	st, shock, or heart	Approximate Interval
/Medical		fail e. List only one cause on each line.  Immediate Cause (Final disease a. Intracranial Hemorrhage				Between Onset and : Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	ř	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	<u> </u>			
	nine	cause. Enter Underlying Cause (Disease or injury that initiated c.				
ed	Examiner	events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, ro the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after class. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ical	d UNPENDED AMENDED				
60, ate be shysici te buri	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	,
687 ertific ding p		past 12 Horitis?	tal death 3 Ectopic p	pregnancy	Month E	Day Year
Box 68760, he death certificate be to the attending physic hed for use as the bur	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Oth	her (Specify)			
O. E at the class that the tached		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part	1. 23e. Did tob	pacco use contribute to	the cause of death?
ires that the signed by the detact	d by	Hypertension		1 Yes	2 No 3 Prob	pably 4 V Unknown
tal Records, cian: The law requirectificate has been sector, page 2 should	Completed	<u> </u>		24a. Was a autops		topsy findings available completion of cause of
Cecc	m o			perform 1 <b>V</b> Yes 2		es 2 No
al R lan: T ertific ctor, p	Be C	25. Was case referred to medical examiner?	26 Place of Death (C	heck only one)		
Vit hysical this call dire	To E	1 Yes 2 No No Inpatient 2 ER/Outpatient			Residence 6 Other	·
Division of Vital Records, rat or Attending Physician: The law requirers after deart. After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death  1  Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	njury 28c. Injury at Work?	1	ow injury occurred	
Siol Atten r death ector: by the	cati	2 Accident Investigation 28e Place of Injury - At home farm street			reet and Number or Ru	ral Poute Number City
Division Spital or Attenchours after death Internal Director:	ertification:	3 Suicide 6 Could not be determined (Specify)	st, radioly, differ ballaning, die.	or Town, Sta		rai Noute Number, Ony
Hospi 24 hou Funer tely fil	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur				
To the Ho within 24 I To the Fu completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	tion, in my opinion, death occu	rred at the time, date a	nd place, and due to th	e cause(s)
F 3 F 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
A		Humele Greeklall, mo	O.C.M.E.		September 3, 20	06
(2)		Name and address of person who completed cause of death (Item 23a)     Pamela Southall, MD	Penn Street, Baltimore,	MD 21201		
	tate	[00 P]	om oueer, ballimole,	WID 21201		
Regis		The state of the s	and the same of th			
		100 to 10				

OCME 2006

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State of Maryland	Department of Health and Mental Hygiene	2	0	0	6

			For State Registrar	State of M	aryland .		artment of <i>tificate o</i>		and Me		iene ∠ U 19. No.	Ub	2995
	Physici /Medic		1. Decedent's Name (First, Middle, L Judy	ast)			Temch	nine		Date of Death Month Potember	Day	Year 2006	3. Time of Death 1:59 A M
	Examir		4a. Facility Name (If not institution, g The Johns Hopkins 5. Social Security Number 6.	Hospital		bringh along	4b. City, Town  Baltin  If Under 1 Year	nore C	of Death		4c. County		N/A
	Funeral Director		052-38-0286 Usual Residence of Decedent	Sex 7. A(1	ge (In yrs. last 59	Yrs.	Months Day		Min.	Date of Birth 77071	Y947	9. Bint Coi	nplace (State or Foreign untry) NY
	Maryland I-f ehow	tor	10a. State 10b. County	)WARD	10c. City, T		cation JMBIA						10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 28a ust be noti	ral Director	10e. Street and Number 10600 GLASS TUN				10f. Zip Code	2104	.4	10	g. Citizen of V	Vhat Co	untry? USA
980	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f ehow guital Examirar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1  Yes 2 X If Yes, Give Year or Dates:	7	1	Was Decedent of Yes, specify Ci		gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)		k, White	ican Indian, , etc. WHITE
Maryland 21215-0036	within 72 ene. then "nat	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or		(Give life. l	tent's Usual Occ kind of work dor DO NOT use reti	ie durina mos	t of working	1	6b. Kind of Bu	isiness/l	ndustry
land 2	ouid be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name (First, Middle, Las	it)			FSON		or's Name (F	First, Middle, M	faiden Sumam	e)	SMALL
	12 sho h and 7 ie m		19a. Informant's Name/Relationship DALY TEMCHINE /			1060	ng Address (Stre		ER PA	TH - CO	DLUMBIA	, MC	21044
Baltimore,	permit. Pages 1 and Department of Healt important: if item 2 eny injury or other onca.		20a. Method of Disposition  1 🛱 Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	ity)	ceme	BIA I	sition (Name of natory or other p MEMORIAL	PARK		2006		MBIA	, MD
Bal	Depa impo eny ir		21. Signature of Funeral Service Lic					STERST	OWN R		PIKESVI		MD 21208
Į.	Physician /Medical		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Septi	c sho	ck	ar the mode of d	ying, such as	cardiac or ri	espiratory arre	st,		Approximate Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, if any secting to immediate cause. Enter Underlying Cause (Disease or injury	. infec	+16n								2 days Sweeks
68760,	ficate be executed physicien and a the burial-transit	edical Examiner	Cause (Disease or Injury that indiated events resulting in death) Last	c. Due lo for as	consequen		iera						Sweeks
P.O. Box 6	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3□	Ectopic pregnar Other (specify)				23d. Date Mor		very Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death t	out not resultin	g in the ur	nderlying cause	given in Part I.		23e. Did toba	~ 1		the cause of death?
Division of Vital Records,	- CQ	Completed								24a. Was an autopsy perform 1 ☐ Yes 2	ed?	Vere aut rior to co leath? Yes	opsy findings available ompletion of cause of 2 No
r Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Xi pati	ent 2 ☐ ER/	Outpatien	t 3 DOA	Mar		Check only one 5 ☐ Resider		ar (Spec	(v)
sion o	ding I h. After funer	Certification: 1	27. Manner of Death  1 Natural 5 Pending investigati 3 Suicide 6 Could not	28a. Date of Inju (Month, Da	ury 28	b. Time of Injury			280	d. Describe hov			77
DİVİ	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		4 Homicide determine	building, e	tc. (Specify)					City or Town,	State)		al Route Number,
	he Hosp n 24 ho he Fune pietely fi	edical	29a. Certifier 1 X Certifying F (Check only one) 2 ☐ Medical Exa	Physician: To the best nminer: On the basis of and manner st	of examination	dge, death and/or inv	occurred at the restigation, in m	time, date an opinion, deat	d place, and th occurred	due to the car at the time, da	use(s) and ma te and place, a	nner as : ind due :	stated. to the cause(s)
	To With	Σ	29b. Signature and title of certifier	30	_Qn	10m	ou Re	nse number	00	S	d. Date signed	er	20,2006
	15		30. Name and address of person who Emilical B Calva 31. Date filed (Month, Day, Year) SEP 2 1 2006	lo, The Joh	death (Item 23	a) (Type, OKIN	Print) 8 HOSPI	tal, 6	.66 No	orth Wol	He St. 1	Bali	11more 21287
- 60	Sta Registr	te ar	SEP 2 1 2006	32. Regist	rar's Signature	boule							

DHMH 17 Rev 1/2001

**Physician** 

/Medical

Examiner

Director

δ

Completed

Be (

2

**Funeral** 

Director

been signed by the should be detached

	20a. Method of Disposition  1	1	Garde	ens Cem 9/	21/06 V		a, New York VICE, P.A.
I Examiner	23a. Part1. Enter the disease, or complications, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do no	t enter the mod	e of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  tributing to death but not resulting in the	3 □Ectopic pr 5 □ Other (sp	ecify)	23e. Did toba	23d. Date of Month	,
Completed b	Colon adenocard Lung adenocard Osteoarthritis				1  Yes  24a. Was an autopsy perform 1 Yes 21	24b. We prio dea	Probably 4 Unknown re autopsy findings available r to completion of cause of th? Yes 2 No
To Be	TE 103 ZX INO	ospital: 1   Inpatient 2   ENOutp		A Other: 4 Nursing I		ce 6 🛭 Other	(Specify Living
Medical Certification;	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28a. Date of Injury (Month, Day Year) 28b. Tin Inju 28e. Place of Injury - At home, farm building, etc. (Specify)	М	8c. Injury at Work? 1 ☐ Yes 2 ☐ No , office	28d. Describe how 28f. Location (Stre City or Town,	eet and Number	or Rural Route Number.
Medical C	29a. Certifier 1 🔀 Cartifying Phys (Check only one) 2 Madical Examin	ician: To the best of my knowledge, der: On the basis of examination and/and manner stated.	or investigation,	in my opinion, death occi	urred at the time, dat	d. Date signed (A	I due to the cause(s)  Month, Day, Year)
	1 1/0'i / ////			H45839		Sept.1	9,2006

DHMH 17 Rev 1/2001

State

Registrar

11+

**ORIGINAL** 

Joseph

5411 West Cedar Lane #202A Bethesda, Md 20814

cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Raffel

SEP 2 1 2006

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Year 08 2006 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 10 M 2□ F Birthplace (State or Foreign Country) Sociel Security Number 7. Age (In yrs. lest birthday) Funeral Year) Months Yrs. Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Marylend 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show th end Mentel Hygiene. 7 ie marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Medical Exprainer must be notified at 1√2 Yes 2 □ No MD Baltimore Directo 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 1503 W. Fayette Street Funeral 21223 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Wes Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1X Never Married 2 ☐ Married altimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced black Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none 18. Mother's Name (First, Middle, Maiden Sumeme) unk 17. Father's Name (First, Middle, Lest) Cherika Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health er important: If Item 27 te any injury or other trau once. UMMC 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) in state 21. Signature of Funeral Sente Licensee Ronald S. W. 22. Name and Address of Facility irector State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Pert 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner attending physicien end for use es the bunel-trensit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events Due to (or es e consequence of) Box 68760. Physician/Medical resulting in death) Last Division of Vital Records, P.O. been signed by the should be deteched Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probabiy þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? Director: After this certificete hes d in by the funerel director, page 2. à**Z** No 2L1No 1 🗆 Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check dnly one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, D.y 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 Accident 3 ☐ Suicide 6 Could not be determined Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò To the Hospital within 24 hours e To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature end title of certif 29d. Date signed (Month, Day, Year) d address cause of death (Item 23e) (Type, Print) XHAND KA 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State 2 Registrar

Division of Vital Records, P.O. Box 68760%	,	Baltimore, N
ospital or Attending Physician: The law requires that the death certificate be executed house stear death	Phy /M Exa	permit. Pages 1 and
uneral Director: After this certificete hes been signed by the attending physicien and	sic led ami	Important: If item 27
ly filled in by the funeral director, page 2 should be detached for use as the burial-transit	ian ica nei	eny injury or other t

			State of Manyland / De		-					
		•	, 101	partment of Health and Me ertificate of Death	Reg. No. 200	6 29961				
	Division		Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death				
	Physici /Medio		ALICE E. WILLIAMS		SEPT. 16 2006	5:30A M				
1	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ath				
	Funeral		FUTURECARE         — HOMEWOOD           5. Social Security Number         6. Sex         7. Age (In yrs. last birthda           219-30-6047         1□M 2 ☑ F         75         Yrs	BALTIMORE CIT  y) If Under 1 Year   If Under 24 Hrs. 8		rthplace (State or Foreign ountry)				
	Director		213 30 0017	Months Days Hours Min.		ARYLAND				
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits				
	Many Many	tor	MD N/A BALT	MORE CITY		Y Yes 2 □ No				
	ges 1 and 2 should be tiled within 72 hours after death with the Maryland to the Heilh and Menial Hygiene. If item 27 ie marked other then "natural, or iteme 23a or 28a-f ehow or other traumatic event, it a Mydical Examinar must be mydified at	Completed by Funeral Director	10e. Street and Number 1357 STONEWOOD ROAD	10f. Zip Code 21 23 9	10g. Citizen of What C	ountry?				
	r deat	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Specifical Mexican, Puerto Rid	y Yes or No- can, etc.) 14. Race - Am Black, Whi					
36	rs afte	y F.	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No II Yes, Give 1 Year or Dates:	1 ☐ Yes 2 XNo Specify:		BLACK				
8	2 hou	ted		edent's Usual Occupation	16b. Kind of Business BALTIMOR	Syludustry my				
21215-0036	within 7 lene. 'then "n	nple	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation ve kind of work done during most of working . DO NOT use retired) ACHER'S AIDE	PUBLIC	С́ноо́Ĺs				
	filed w Hygier ther th		12 1 17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Sumame)					
lan	Mental I	To Be	LUTHER M. JONES	Y JONES						
Maryland	nd 2 should Ith and Men 27 le marke r traumatic			iling Address (Street and Number or Rural F 0 6 LANDBECK RD, B	Route Number, City or Town, State, ALTIMORE, MD	Zip Code) 21207				
Je,	of Hee		cometen/ c	position (Name of Date ematory or other place)						
Baltimore,	ment tant: It jury o		4 Donation 3 Other (Specify)	ION CEM. 9/21/						
Ball	permit. Pages 1 and 2 Department of Heelth a Important: If item 27 is eny injury or other tra		1 / Tenting of 1. Cony	22. Name and Address of Facility HOW! 4600 LIBERTY HEIO	GHTS AVE, BALT	ME 21207 SIMORE, MD				
			23a. Party Enter the disease, or complications that caused the death. Do not established the death. Do not established the cause on each line.	inter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death				
1	Physician /Medical		Immediate Cause (Final disease of condition resulting in death)  a. ATHERS CLOSOTT Due to (or as a consequence of):	c Cordionascalor	Discore	Unkon				
	Examiner		Consession	ent failur		UNY NOWS				
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  Cause (Disease or injury that initiated events  c. Carabaccustor Academy							
¥	death certificate be executed e attending physicien and of for use as the burial-transit	The second process of the second process of								
68760	cate be ohysicie the bu	dical	d							
Box 6	leath certificate attending phy I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	livery				
.O. Bo	e death he atter	by Physician/Medi	in the past 12 modifies?	□ Ectopic pregnancy □ Other (specify)	Month	Day Year				
<u>α</u>	The law requires that the de sie hes been signed by the a page 2 should be detached	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute t	to the cause of death?				
Division of Vital Records,	equires en sign ould be	ed b	,		1  Yes 2  No 3 P	robably 4 Onknown				
eco	lawrenes be	Completed			autopsy prior to	utopsy findings available completion of cause of				
<u>a</u>					performed? death? 1 Yes 2 No 1 Yes	s 2 No				
Ķ	Physician: The lav this certificete hes ral director, page 2	To Be	25. Was case relerred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ent 3 DOA Other: 4 Nursing Home	Check only one)  5 ☐ Residence 6 ☐ Other (Spe	20(6)				
οľ	ng Phys ter this neral di		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28c	d. Describe how injury occurred	scriy)				
sioi	eath. for: Af	catic	2 Accident investigation	M 1 Yes 2 No						
Divi	lor At after d Direct	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 281	Location (Street and Number or R City or Town, State)	fural Route Number,				
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause(s) and manner a at the time, date and place, and du	s stated. e to the cause(s)				
	othe ithin 2 othe omple	Med	one) and manner stated.  29b (Signature and title of certifier	29c. License number	29d. Date signed (Mon	th. Day, Year)				
	~ s ⊢ ō			D 00 59056	9/18/06					
	1		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)						
	0		31. Date liled (Month, Day, Year)  32. Registrar's Signature	MO (Suite 106)	21215-					
2	Sta Registr		SEP 2 1 2006							

DHMH 17 Rev 1/2001

		1 - For State Registrer	State of Maryland / I	Department of Health and Certificate of Death		2006 29961		
Physic		1. Decedent's Name (First, Middle, Last	")		2. Date of Death Month Da September	3. Time of Death		
/Med Exami		Olivia Zepp  4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		County of Death		
		Crescent Cities	Nursing Home	Riverdale		rince George's		
. Funeral Director		180-01-1602	7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) 917 Missouri		
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits		
Many a-fsh	to	MD Prince G	George's Rive	rdale		1 ☐ Yes 2√7 No		
Definition is, Interpretable and 2 in the Industrian Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, it whe Medical Engineer in that he inclined at any injury or other traumatic event.	Funeral Director	10e. Street and Number 4409 East West H	lighway	10f. Zip Code 20783		tizen of What Country? USA		
lems er tim	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.		
ours afte	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: white		
natu	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occupation     (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b. K	(ind of Business/Industry		
withir ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	clerical		insurance		
il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			me (First, Middle, Maiden			
should be a marked o	To B	Gearhart Geisel						
d 2 sh d 2 sh th and th and traum		19a. Informant's Name/Relationship (T)  Larry Jennings/fr		o. Mailing Address (Street and Number or R				
s 1 and f Health frem 27 trem 27		20a. Method of Disposition	20b. Place o	07 Apple Grove Road  f Disposition (Name of rry, crematory or other place)		ocation - City or Town, State		
Pages nent of h int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☒ Other (Specify)	Removal from State	ly, crematory or other place)				
permit. Pag Department Important: I any injury o		21. Signature of Enneral Service Licent	Nade Director	State And Comy Found Baltimore, MD 21	655 W. Balt 201	imore Street		
		23a. Part1. Enter the disease, or comp shock, or leart failure. List only o	ncations that caused the death. Do	not enter the mode of dying, such as cardia		Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition		6 Structine lu	ua Disea	Onset and Death		
/Medical Examiner		resulting in death)	Due to (or as a consequence	of):		/		
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	of):				
cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					
e be exe /sician a	ai E	resulting in death) cast	Due to (or as a consequence	of):				
ficate phys sthe	edicai	•	d					
h certi	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death	a 3□Ectopic pregnancy		23d. Date of delivery		
wrequires that the death certific been signed by the attending f should be detached for use as	Physician/Med	in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death	5 Other (specify)		Month Day Year		
that the hold by detail		Part II. Other significant conditions co	ntributing to death but not resulting i	23e. Did tobacco	use contribute to the cause of death?			
equires an sign	ed by	Pankitus	1 ☐ Yes 2	2 No 3 Probably 4 ☐Unknown				
law re as be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
The The cate h	Con				performed?	death?		
sician certifi rector	o Be	25. Was case referred to medical examiner?	Hospital:	04	ath (Check only one)	a 5700 - 10 - 11 - 1		
B Phy er this	I	27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	dome 5 Residence 28d. Describe how injur			
auth. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Fear)	Injury Work?  M 1 Tyes 2 No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fabuilding, etc. (Specify)	arm, street, factory, office		Locetion (Street and Number or Rural Route Number, City or Town, State)		
Hospit 24 hour Funere	edical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge iner: On the basis of examination are and manner stated.	e, death occurred at the time, date and place ad/or investigation, in my opinion, death occ	e, and due to the cause(s urred at the time, date and	) and manner as stated. d place, and due to the cause(s)		
To the within To the compl	Me	29b. Signature and title of certifier	121 - 1	29c. License number		te signed (Month, Day, Year)		
		Mullen	Iller hi	7 100182	2 14	8 eptember 2006		
			ompleted cause of death (Item 23a)	(Type, Print)	hatter-11	MIN 20781		
St	ate		ompleted cause of death (Item 23a)  APP MD 4723 (  32. Registrar's Signature	Weensburg Ed A	yatts villy	MID 20781		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1,2006 **Physician** SEPT. FRANCES Year I. ANDREWS Д:30 A м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY 5. Social Security Number 224-22-6614 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) JAN • 9 , 1921 Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 85 Yrs. Director VIRGINIA Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f shov virse must be notified at MD. MONTGOMERY ROCKVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: r then "neturel", o WHITE δ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be tiled within 72 l Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "net any injury or other traumatic event, the Market 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SAMUEL ISH ANNIE GOODE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK M. ANDREWS -HUSBAND 9501- VEIRS DR. #2 ROCKVILLE, MD. 20850 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State UNION CEMÉTERY 9/7/2006 LEESBURG, VA. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HYSONG CO., INC. CC0367 113-p 2222-WISCONSIN AVE., NW, WASH. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Domentia **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit certificate be executed Due to (or as a consequer attending physician P.O. Box 68760 Physician/Medicai the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţō in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗆 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; or Attending 1X Natural 5 Pending investigation s after death. 1 Yes 2 No 2 Accident tilled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funerel Direct 4 | Homicide the Hospitel t≅ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 701 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Mo 2006 Registrar

/DR

5.

YANG

9701egistrar's Signature 32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VEIRS DRIVE, ROCKVILLE,

20850

MD.

06-06555 Marcellous Alford

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Crivial yland / Department of Treath and Wentan Certificate of Death	_	eg No OOC	2006			
Physiciar Medical Examin	n/	1. Pecedent's Name (First, Middle, Last)  MARCEllous  C. ALFORD	2. Date of Dea Month Septembe		11 hrs			
and a		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De 27000 Old State Road Crisfield		4c. County of Death Somerset				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Birthplace	(State or			
Director	1	204-60-3064 1 XM 2 F 20 Yrs.	/lin. 11-15-	1979 Foreign Country)	PA			
vany	ł	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	<del></del>		nside City Limits			
ryland a-f shov	ctor	MD SOMERSET Crisfield  10e. Street and Number 10f. Zip Code		0g. Citizen of What Country?	Yes 2 X No			
Baltimore, MD 21215-0036  Demit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	27115 Crisfield-Marion Road 21817		U.S.A				
leath wit r items 2	unera	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No		14. Race - American Indi White, etc.	ian, Black,			
rs after c		3 Wildowed 4 Divorced If yes, Give Year or Dates:  1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind	of work done	Specify: Slac	አ			
72 houn	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use		Cleaning				
d within ygiene.	Completed by	17. Father's Name (First, Middle, Last)  18. Mother's Name	me (First, Middle, I		<b>,</b>			
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "matural". matic event, the Medical Examiner.	8   B		olia	Alford				
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than item 27 is marked other than	]۲	LACOlia Alford - Mother 77/15 Cristield	MAP	nber, City or Town, State, Zip Co	<i>'</i>			
Nore, M gges I and 2 at of Health t: If item 2					State			
Baltimore, permit Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Tame and Address of Facility	1-06-06	Hans Dury				
മ്≘്ള Physician	+	21. Signature of Funeral Service Licensee  22 name and Address of Facility  314 cov5 ST.  23a. Part I. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardia	is field	MD 2-1817	oximate Interval			
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries			veen Onset and Death			
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause  Clisease or injury that initiated  C:  C:						
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Box 68 e death certif the attending ed for use as	Physiciar	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify) 9 Unknown						
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the start death  al Director: After this certificate has been signed by the funeral director, page 2 should be deated.	<b>⊢</b> [	27 Manner of Death 1 Natural 5 Pending 28a Date of Injury Sep 1, 2006 28b. Time of Injury 28c Injury at Work? 1 1 Yes 2 No		now injury occurred fixed object collision				
Division ospital or Attent hours after death hours after death uneral Director: y filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Rural Rout	te Number, City			
Divi ospital or Hours after uneral Dir		4 Homicide determined (Specify) Major Road / Highway  29a Certifier   Certified Physician To the best of myleculadars death accurated this time days and the control of the		State Road, Crisfield, MD	)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a money one)		and place, and due to the cause				
	Ž	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d Date signed (Month, Day September 2, 2006	r, Year)			
	-	30. Name an address of person who completed cause of death (Item 23a)		2, 2000				
Sta	to	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI  31. Date filed (Month, Day, Year) 32. Register's Signature	D 21201					
Registr	-	SEP 0 7 2006 Bleen & South						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Clifton C. Arringdale 1:00 AM 2006 /Medical September 4. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28 Raven Court E1kton Ceci1 Hours Min. B. Date of Birth Feb. 5, 1932 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1<del>√</del>M 2□F 214-30-5857 74 Baltimore, MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 17 is marked other than "natural, or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Heelth and Mental Hygiene. 28 Raven Court Completed by Funeral 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Tell Yes 2 No Specify: No Specify: Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Clifton C. Arringdale Margaret Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 to other tra Susan Arringdale/Wife 28 Raven Court Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September 6, 2006 Mayerdale Crematory Newark, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home Robert T. Crouch PER DVR 127 South Main St. North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) and Death **Physician** anislatic Cancer lh Known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Probably has been sig je 2 should b 1 ☐ Yes 2 ☐ No 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate ha autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 8 No 25. Was case referred to medical examiner? funetal director 26. Place of Death (Check only one) Other: 4 Nursing Home \$ Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certifidation; To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Afte, 5 Pending investigation Natural death. 2 Accident М 1 ☐Yes 2 ☐ No i Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 12 Certifyin 2 Physician: To the heal of my kn. wedge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/06/06 D54086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Jamil Khatri
31. Date filed (Month, Day, Year)
SEP 0 8 2006

MD

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High Street Ste 104 Elkton, MD 21921

CIVISION OF VICE MOONING BY A CONTROL OF Attending Division. The law requires that the death conflicts he executed
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eletery filled in by the funeral director, page 2 should be detached for use as the burial-transit

		For State Registrer	State o	of Marylar	nd / Depa	artment <i>rtificate</i>	of He	ealth and leath	Mental Hy	giene		299	965	
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/Medica Examine	3	4a. Facility Name (If not institution, gi	ve street and nu					ocation of Dea		4c	. County of De	ath	A	
Funeral Director		Social Security Number 6.	Sex 1 □ M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1	nham Year Days	If Under 24 Hrs Hours Min		rth ay, Year)	rince G	eorges inthplace (State Country)		
Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  MD Prince G	Coorgos		ty, Town or Lo	ocation						10d. Inside (		
with the A a or 28a-	Director	10e. Street and Number		Lan	mani —	10f. Zip C				10g. Cit	tizen of What (	Country?		
urs a	by Funeral	9885 Greenbelt Ro  11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced		2 No		2070 Was Decede If Yes, specif	nt of His y Cuban,	panic Origin? ( Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	USA  14. Race - An Black, Wh  Specify: W	rite, etc.		
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ould be filed Mental Hyg arked othe atto event,	To Be C	17. Father's Name (First, Middle, Las Anthony Adinol						8. Mother's Na	me <i>(First, Middle</i> enica Ru	e, Maiden		TCH VI	I A	
and 2 she salth and n 27 is m er traum		19a. Informant's Name/Relationship Kerri Rowan/Niec							ural Route Numb					
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= 0.0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	1 Live	itcome of pregni birth 2 Peta nant at time of c	al death 3[	Ectopic preg					23d. Date of d Month	elivery Day	Year	
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hysician his certifi I director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital: 1 🗆	Inpatient 2	ER/Outpatier	nt 3□ DOA	Other		ath (Check only Home 5 ☐ Res		6XOther (Sp	Assis PecifyLivin	ted	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely lifted in by the funeral director,	Certification:	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	on he	nth, Day Year)	28b. Time o Injury	М		nt es 2 □No		e how injury occurred				
urs after or At or all Directified in by		4 Homicide determined	d 289. Place build	e of Injury - At h ing, etc. (Speci	fy) 				City or To	wn, State	9)	Rural Route Nur	nber,	
the Hosp nin 24 ho the Fund apletely f.	ledicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	iminer: On the b	e best of my kno pasis of examina iner stated.	owledge, deat ation and/or in	vestigation, in	n my opii	nion, death occ	e, and due to the urred at the time	date and	d place, and du	ue to the cause(	s)	
To Too	Σ	29b. Signature and title of cettifler	2 ones				License i				-	nth, Dey, Year) C 3, 20(	06	
2		30. Name and address of person who Thomas E. Masler					Dri	Lve #31	6 Greenb	elt,	MD 20	0770		
Stat Registra		31. Date filed (Month, Day, Year) SEP 0 6	32. F	gistrar's Signa		hade								

			1 - For State Registrar	State of M	arylan		artmen rtificate				lental Hy	giene	711116	29	966
	Physici /Medio		1. Decedent's Name (First, Middle, L Robert Lee Adams	s, Sr.							2. Date of De Month Septem	Da	y Year 2 2006		of Death
4	Examir		4a. Facility Name (If not institution, granne Arundel Medi	cal Center	<u> </u>		4b. City, Town, or Location of Death Annapolis					4c. County of Death  Anne Arundel			
-	Funeral Director		5. Social Security Number 6. 214-26-1916 Usual Residence of Decedent	Sex 7. A 13€ M 2 F	90 (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under a	Min	8. Date of Bir (Month, Da 01/28/	th ay, Year) 1916	Nor	nthplace (State Country) th Carol	
	Maryland B-f show	tor	10a. State 10b. County Maryland Anne Ari	ındel	10c. Cit	y, Town or Lo	ocation						-	10d. Inside	City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then *natural; or Iteme 23e or 28e-f show any njury or other traumatic event, the Medical Exprining must be notified at ance.	eral Directo	10e. Street and Number 555 Poplar Drive		F	0 10	10f. Zip	40				Uni	ted Sta	ites	
036	ours after de rai', or item Examination	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 1 Yes 2 ☐ If Yes, Give Year or Dates:	No No		was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	>-	14. Race - Am Black, Wh Specify:		
21215-0036	within 72 ho noe. .hen *natur ne Medical	Completed	15. Decedent's Elementary/Secondary (0-12)		5+)	(Give	dent's Usua kind of wor DO NOT us	rk done d	urina most	t of workii	ng	16b. Kind of Business/Industry			
land 2	id be filed v ental Hygie ked other t ic event, In	To Be Co	to 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Mother's Name (First, Mother's Name								Civil Service Maiden Surname)				
Maryland	and 2 shoul alth and M 27 is marl or traumati	ī	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  Brenda C. Adams/Daughter In Law 555 Poplar Drive, Riva, Maryland 2114									Zip Code)			
Baltimore,	Pages 1 ament of He tent: If item		20a. Method of Disposition  1 Burial 2X Cremation 3 4 Donation 5 Other (Spec	□Removal from State	20b. P	Place of Dispo emetery, crer as Cre	sition (Nam natory or or mator	ne of ther place <b>y</b>	9)	9 – 4	1 – 0 6	Edg	ocation - City o ewater,	Mary1	
Ball	Depart Depart Import any in		21. Signature of the ray Service Lig			29	73 So	1omo:	ns Is	land	Rd, Ed	dgew	s Funer ater, M	D 2103	7
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. COU	ine.									Approxim Interval B Onset an	etween
death certificate be executed the extending physician and control of for use as the burial-transit the property of the control		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. atria Due to (or as	1 f	uence of):	Vat	ion	wit	h ro	apid r	95/	onse	5 da	y5 y5
.O. Box 6	at the death certifics by the attending phateched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal	I death 3 □	Ectopic pro						23d. Date of de Month	elivery Day	Year
rds, P.	The law requires that the site hes been signed by the page 2 should be detache	þ	Part II. Other significant conditions  Adenocare	inoma	of	lung		ause give	n in Part I.		23e. Did t		use contribute t □ No 3 □ P	o the cause of	
Division of Vital Records,	raicien: The taw re s certificate hes be lirector, page 2 sho	Completed	exacerbation of COPD  24a. Was an autopsy perform 1 yes 25							osy	prior to completion of cause of		s available cause of		
of Vita	Physicien this certifi al director	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hospital: 1 Alnpati	ent 2	ER/Outpatien		A Othe	r: 4 🗆 Nur	rsing Hon	(Check only one 5 ☐ Resid	dence	6  ☐ Other (Spe	ecify)	
ision	of or Attending Physicien: after death. I Director: After this certifica d in by the funeral director, a	Certification:	250. Time of Death   280. Injury at   280. Injury at   280. Injury at   280. Injury at   280. Describe how injury   280. Injury at   280. Describe how injury   280. Injury at   280. Describe how injury   280. Injury at   280. Describe how injury   280. Injury at   280. Describe how injury   280. Injury at   280. Describe how injury   280. Injury at   280. Describe how injury   280. Describe how i							y occurred					
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	To the Hospitel within 24 hours a To the Funeral C completely filled	Medical	(Check only one)  2 Medical Example 29b. Signature and title of certifier	and manner st	f examinal ated.	tion and/or inv	estigation,	in my op	number	h occurre	d at the time,	date and 29d. Dat	d place, and du te signed (Mon	e to the cause	
	54		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	200	)29	ケフ	1 f+n=	09,	103/2	2006	
	Sta Registr		Paul BRYCz M 31. Date filed (Month, Day, Year) SEP 0 5 20	37. Regist			7) Y	,, ~,	/ ) .	-, 0	17 011	, , , ,			

State of Maryland / Department of Health and Mental Hygiene 200629967 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 24, 2006 Steven Alushin 9:12A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13103 Wellford Drive Beltsville Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth March 7, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F West Virginia 184-18-0585 83 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ms 23a or 28a-f short Maryland Prince George's Beltsville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13103 Wellford Drive 20705 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ₩₩∏∏ r then "natural", or items the Medical Examiner or Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Completed by 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) Electrician Standard Electric Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 is marked other t juyy or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Alushin Mary Ripper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Alushin -wife 13103 Wellford Drive Beltsville, Maryland 20705 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If Ite
any Injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 9/5/2006 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 FLU CU Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Carcinoma Lung w/ brain metastases **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicier IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3□ DOA this. hours after death. Ineral Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 ⚠ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shard Us D26287 September 5, 2006 10 30. Name and address of person wt mpleted cause of death (Item 23a) (Type, Print) Michael J. Berard, MD 7305 Baltimore Avenue, #107 College Park, Maryland 20740 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 06 Registrar

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 29968 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 4, **Physician** ADELE MARY CLAGETT AVENT 2006 12:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ ¥F 577-30-3667 84 DECEMBER 20, 1921 Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location in than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits t√□Yes 2□No Funeral Director MARYLAND PRINCE GEORGES FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2020 BROOKS DRIVE #404 20747 UNITED STATES filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUILDING SERVICE WORKER FINANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental H tent: If item 27 is marked oth jury or other traumatic even Be JOSEPH CLAGETT EDNA GRACE MIDDLETON CLAGETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE V. AVENT / DAUGHTER 2020 BROOKS DRIVE #404, FORESTVILLE, MARYLAND 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) QUANTION NATIONAL CEMETERY SEPTEMBER 15,2006 TRIANGLE, VIRGINIA Standard of Fungral Service Aconses 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND M00583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) FATAL CARDIAC ARRHYTHMIA **Physician** /Medical Due to (or as a consequence of) Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit HYPERTENSION Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as **IF FEMALE:** use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: Certification: To 1 ☐ Yes 2 🛣 No 1 Minpatient 2 ER/Outpatient 3 DOA His 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after dec. 1 X Natural fnfury 1 Tes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a Medicai 29a. Certifier 1 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9-5-06 30. Name and ss of per se of death (Item 23a) (Type, Print) HOSPITAL CHEVERLY, GARY LITTLE 3001 MD 1,MD 31. Date filed (Month, Bay, Year) 32. Restrar's Signature State Registrar SEP 0 8 2006

			State of Maryland / Dep 1- State of Maryland / Dep Phys.PGC 9-14-06Ce	artment of Health and Wartificate of Death	lental Hygiene Reg. No	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Winfred H. Anders		2. Date of Death Month Sept. 6,	3. Time of Death 2006 2:55P M
	Examir		4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Clinton  If Under 1 Year   If Under 24 Hrs.	Pr B Date of Birth	County of Death
	Funeral Director		294-26-5561 1 X 2 F 85 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	Month, Day, Year) April 21,	9. Birthplace (State or Foreign Country) 1921 Massachuset
	Ba-f ehov	Director		e Hills		10d. Inside City Limits 1 ☐ Yes 2√☐ No
	238 or 2	rai Dire	10e. Street and Number 6006 Walnut Street	10f. Zip Code 20748	10g. Cit	izen of What Country?
036	ours after des ral', or iteme Examiner m	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married If Yes, Give Year or Dates: 45	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 XNo Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or iteme 23a or 28a-f show important: If term 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, Ite Madical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) Agent	ng	ind of Business/Industry leral Government
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e, Mar	1 and 2 sho Health and Iom 27 io m		Lisa Swaim - Daughter 3611	ing Address (Street and Number or Rura  Damascus Rd.,  iosition (Name of	Brookevil	
Baltimore,	mit. Pages bartment of l cortant: if Its injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Kalas C	1	8,200 <b>£</b> dg	rewater, MD
Ä	Depariment Department of the post of the p		23a. Parl .Enter the disease, or complications that caused the death. Do not en	22. Name and Address of Facility  eorge P. Kalas  160 Oxon Hill Ro	a., Oxon	Hill, MD 20745  Approximate
	Cate be executed / Medical Examiner: the purial-transit the purial-transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	Kidney		Interval Between Onset and Death
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tal Reco		e Completed	25. Was case referred to medical		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Division of Vital Records,	ing Phys After this uneral di	To B	examiner?  1		ne 5⊡ Residence ( 28d. Describe how injur	
DIVIS	후 # 등 드	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, State	
	I 4 F 0	edicai	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deat of the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a svestigation, in my opinion, death occurred.	and due to the cause(s) ed at the time, date and	and manner as stated. I place, and due to the cause(s)
^	To the To the complet	₹	29b. Signature and title of certifier	29c. License number DY 647 8	29d. Dat	re signed (Month, Day, Year)
4	(12) Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, SUYES h. A. VOLLEY TO TO TO THE TOTAL TO THE TOTAL TOT	Print) Sumatts Rel. (	Clinton	mD20735
	Registr		SEP 0 8 2006 Scan & Span	W		

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	Physici	an	1. Decedent's Name (First, Middle, Last							2. Date of De Month	ath Da	ay Year		e of Death
	/Medic		Rodel Gasp		incula						5, 2	006	6:4	47 P M
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	-		Fort Washington H 5. Social Security Number 6. Se	ospital x 7. Age (In yrs.	last hirthday)	For If Under		shing	ton	8 Date of Bir	th	a Bi		ate or Foreign
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4	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):		• /_							
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Вох	eath certific attending p	Z	230. Was decedent pregnant	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		Tatania are						23d. Date of de	livery	
.0	deat	sicia	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4 Pregnant at time of o		Ectopic pre Other (spe						Month	Day	Year
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Sec.	e law	npi								24a. Was autop	osy	24b. Were a prior to	utopsy findir completion	ngs available of cause of
		S									rmed? 2 X No	death?	s 2 No	
Zi Zi	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	0		Othe			Check only o				
o		. To	1  Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		A Culto	' 4 ☐ Nur		8d. Describe I		6 Other (Spe	ecify)	
on	ding th.	tion	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day Year)	Injury	м	3c. Injury Work' 1 □ Y	?` 'es 2 □ N		00. 50001100 1	iow inju	ry occurred		
Division	Attending r death. sctor: After	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory,						nd Number or R	lural Route N	lumber,
É		Certification:	4  Homicide determined	building, etc. (Special	ry)					City or Tov	vn, State	9)		
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, death	occurred a	at the time	e, date and	place, a	nd due to the	cause(s	) and manner a	s stated.	
	To the H within 24 To the Fi complete	ledical	one)	and manner stated.	and and or in				ii occurre					
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	M 100,00	7		License		- 1			te signed (Mon		r)
	72		popular	11 Marie	$\sim$		78	-27	1		Sept	. 7, 20	06	
K	(3)		30. Name and address of person who co				ىر ج	102 1	75 1 2 -	rf in	20	602		
	Sta	to	Krishan Mathur, M. 31. Date filed (Month, Day, Year)	D. 3500 O.LQ V		CON K	u. #	102 W	атао	LI, MD.	. 20	002		
	Registr		SFP 9 8 2006	Marie &		2								

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15 ROW D 3:12 AM ONZO 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5 risticld omer set If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOU, 25 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 18 M 2□ F 217-28-3053 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at risticle 1 No 2 No Completed by Funeral Director omerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH or items 23a or 21817 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X es 2 ☐ No If Yes, Give 14. Bace - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Black Year or Dates: "natural", Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) rthan Elementary/Secondary (0-12) College (1-4or 5+) DUPELVISOR ARVER Hall permit. Pages 1 and 2 should be filed Department of Health and Mentat Hygin Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Brown Nora Alonzo 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) risfield 12 MH MD 2181 217 N Edona ite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 09-05-06 \* 4 ☐ Donation 5 ☐ Other (Specify) eran ed Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility uncial Home once. Long 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer LUNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) the attending physician Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? detached for Day 5 Other (specify) P.O. ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1∠Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed 2 No 1 Yes 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other Certification; To 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation 2 ☐ Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Pocomoke Coty 305 TENTA ST FLEURY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

0 5 2006

29972

HAKKIET JANN	
BARRON,	36
IAME KNOWN TO PHYSICIAN: BARKON, HARKLET	e, Maryland 21215-0036
2	Mary
KNOWN	3altimore, M
AME	Balti

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		- State Registrar			Cer	tificate of l	Death		Reg. No.	.000	20010
40%		1. Decedent's Name (First, Mida	lle, Last)					2. Date of D	eath		3. Time of Death
Physici /Medic		Harriet Jar	ney Barron					SEPTE	MBER 6	2006	5:05 A. M
Examin		4a. Fecility Name (If not institution	on, give street and num	ber)		4b. City, Town, o	Location of Death	,	4c. C	ounty of Death	1
		VA MARYLAND HE	ALTH CARE	SYSTEM			PERRY PO	INT		CECI	L
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth (	9. Birthp	lace (State or Foreign
Director		217-12-5782	1 □ M 2X F	94	Yrs.	Months Days	Hours Min.	(Month, D 08/20		Brad Cour	ley Beach,
2		Usual Residence of Decedent								DI aq.	bedeng
tural, or items 23a or 28a-f show al Exercit er must be notified at		10a. State 10b. County	y	10c. City, To	own or Loc	ation				1	0d. Inside City Limits
or 28a-f short	Director	Maryland Cec	:11	Risi	19 Su	n					1 ☑ Yes 2 ☐ No
or 28a-f	rec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cour	itry?
23a c		424 Washingto	n Schoolho	use Road		2191	1		Unite	ed State	) C
items 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. W		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or N		. Race - Americ	an Indian,
or ite	Ē	1 Never Married 2 Mar	Armed Ford	QNOU.S.	li II	Yes, specify Cuba		Hican, etc.)		Black, White,	etc.
le di	by	3 Widowed 4 □ Divorce	d Year or Dat	Coast Gu	lard 1	☐ Yes 21xtNo	Specify:		S	pecify: Whi	te
natural azical Ex	Completed	15. Deceder	nt's Education est grade completed)	1943-198	a. Deced	ent's Usual Occup	ation during most of work	rina	16b. Kind	of Business/Inc	dustry
C 20	ple	Elementary/Secondary (0-12)	College (1-4		life. D	O NOT use retired	i)	urig			
gien er th	lo C	12			Of	fice Man	ager		Nav	7a1	
Department of Health and Menial Hygiene. Importent: If Item 27 is marked other thas any injury or other traumatic event, If a N once.	Be (	17. Father's Name (First, Middle,	, Last)				18. Mother's Nam	e (First, Middle	e, Maiden Si	u <i>mam</i> e)	
Aente rked tic e	Tof	John R. Janne	У			1	France	s Gala	tian		
Du B	•	19a. Informant's Name/Relation:	ship (Type, Print)	1:	9b. Mailing	Address (Street	and Number or Rur	al Route Numb	per, City or 1	Town, State, Zip	Code)
alth a 27 ls		Barbara Barr	on /Daughto	_	2400	Dinas II					01001
te me to		20a. Method of Disposition	DII/ Daugitte	20b. Place	of Dispos	Biggs II	ignway p	Date	20c. Loca	lary Land	21901 wn, State
y or y		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from St	ate	74 057	atory`or other plac Cemetery	Septe	ember	37	1	
in the		21. Signal Fundal Service	1	Day (	TEW	Name and Address	ss of Facility	2006	Nort	n East,	Mary land
Depa Impo sny ii		VYALLI			1		CI	.ouch ri	uneral	Home	
		23a. Part1. Enter the disease, o	y someliantions that an	and the death. D	1	27 South	Main Str	eet No	orth E	last, Ma	ryland 21
		snock, or near failure. Lis	t only one cause on ear	ch line.	o not ente	r the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
nysician	Ì	Immediate Cause (Final disease or condition	ACUTI	E MYOCARI	DIAL	INFARCTI	NC				UNKNOWN
Medical kaminer		resulting in death)	Due to (or	as a consequenc	e of):						
Xarrin er		Sequentially list conditions,	b								
==	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequenc	e of):						
icien and burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	С								
ding physicien and se as the burial-transi		resulting in death, cast	Due to (or	as a consequenc	e of):						
physic s the b	/Medical		d								
O) (d)	Med	IF FEMALE:									
		23b. Was decedent pregnant	23c. If yes, outco	nme of pregnancy	th 3 🗆	Ectopic pregnancy			230	d. Date of delive	гу
been signed by the etter should be detached for u	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death		Other (specify)				Month	Day Year
by th	hys	9 🗆 Unknown	9C Onknow	m 							
r death. ector: Afler this certificate has been signed by the elter by the funeral director, page 2 should be detached for u	by P	Part II. Other significant conditi	ons contributing to dea	th but not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
n sig	P							1 🗆	Yes 2□	No 3 Prob	ably 4 🕭 Unknown
sho	Completed							24a. Was	an	24h Were autor	nev findinge available
ge 2	E I							auto	psy ormed?	prior to con	osy findings available appletion of cause of
licate		25.11						1 ☐ Yes	2 <b>X</b> No	1 ☐ Yes	2□ No
recto	Be	25. Was case referred to medica examiner?	Hospital:			Othe	26. Place of Deat				
this die	ဥ	1 Yes XXNo	1 X Inc	patient 2 ER/C			4   Nursing Ho				)
After	o	27. Manner of Death 1 XNatural 5 ☐ Pendir	ig .	Day Year)	. Time of Injury	28c. Injury Work		28d. Describe	how injury o	occurred	
eath tor: /	cat	2 Accident investi	igation not be			M 1 🗆 '	res 2 □ No				
irecl irecl n by	Certification;	4 Homicide determ	nined   200. Place U	Injury - At home, , etc. (Specify)	farm, stre	et, factory, office		28f. Location ( City or To	Street and N wn, State)	Vumber or Rura	Route Number,
rel D											
within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1  Certifyin (Check only one) 2  Medical	ng Physician: To the b Exeminer: On the bas and manne	is of examination a	ge, death and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and pla	nd manner as st ace, and due to	ated, the cause(s)
	Me	29b. Signature and title of certifie	or // -	1		29c. License	number		29d. Date s	signed (Month, L	Day, Year)
orthin orthin		11. 11	2 Blens	an .	110	T	042800			MBER 6,	
To the		1 1/2 2 at NK	3 Proving	0 14		1	J-12000		SUPIL	LIDER O	2000
within To the		- Graine			-						
Wilhin William Compl		30. Name and address of person THOMAS BIONDO,									•

		_	1 - For State Registrar	State of Ma	aryland	d / Depa	artment rtificate	of He	ealth a <i>eath</i>	nd M		iene ,	2006	29973
	Physici /Medic		1. Decedent's Name (First, Middle, Last Helen C	_	ver						2. Date of Deat Month	h Day	Year 200 6	3. Time of Death  0132 M
	Examir		4a. Facility Name (If not institution, give FanInSULA RAGIONOI	street and number) Medical	Cen	Ter	4b. City, T		ocation of	Death		-	ounty of Deat	١.
	Funeral Director		5. Social Security Number 6. S 197–24–1507 1  Usual Residence of Decedent		9 (In yrs. la 88	ast birthday) Yrs.	If Under 1 Months	Year Days	Hours		8. Date of Birth (Month, Day, 3/19/19.	Year) 18	Co	nplace (State or Foreign untry) nsylvania
	a-f show	ctor	10a. State 10b. County  Maryland Wicomic	co	,	Town or Lo								10d. Inside City Limits 1 X Yes 2 ☐ No
	h with th	Funeral Director	10e. Street and Number 900 Booth Street				10f. Zip 0				11	og. Citize US <i>I</i>	n of What Co	untry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or items 23s or 28s-f show aumatic event, the Madical Examinar must be notified at	Ď	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent   Armed Forces?   1 Yes 2 N   If Yes, Give   Year or Dates:	_		Was Decede If Yes, specif		panic Origi Mexican, Specify:	in? (Spec Puerto P	cify Yes or No- lican, etc.)		Race - Ame Black, White Decify: Wh	
Maryland 21215-0036	l within 72 ho iene. r then "netur the Medical.	Completed	15. Decedent's Ec (Specify only highest gra	ucation de <i>completed)</i> College (1-4or 5	+)	16a. Deced (Give life. I	dent's Usual kind of work DO NOT use Naker	Occupati done du retired)	on ring most	of workin	g		of Business/I	·
/land		To Be C	17. Father's Name (First, Middle, Last) Henry Wolfgang					1			(First, Middle, M	faiden Su		
, Mar	ges 1 and 2 should to f Heelth and Mer If Item 27 is marks or other treumatic	1 8	19a. Informant's Name/Relationship (7				-				Route Number, , Princ	•		
altimore,	permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 is any Injury or other trai		20a. Method of Disposition  1 □ Surial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20ь. Pla Oak	ace of Dispo metery cren Hall metery	sition (Name natory or oth River	of er place) SIGE	9	Da 9/5/0			tion - City or 1	
Balt	Depart Depart Import any inj		21. Signature of Funeral Service Con	reg CF.	560								ional MD 21	Association 804
1-	Physician /Medical		23a. Part1. Enter the disease, or companies, or heart failure. List only a limediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each lin	θ.	Ty Por	er the mode	of dying,	such as ca	ardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	NEU	WNI.	A	_						
8760,	sate be executed hysicien and the burial-transit	dicai Exan	that initiated events resulting in death) Last	c. Due to (or as a	a conseque	ence of):								
.O. Box 6	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of the live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal o	death 3□	Ectopic pred					23d	. Date of delin	rery Day Year
ords, P	w requires that the been signed by th should be detache	5	Part II. Other significant conditions of	ontributing to death bu	it not resul	lting in the ur	nderlying cau	ise given	in Part I.			acco use		the cause of death?
Vital Records,	The law ate has b page 2 s	Completed	ULINART	TRACT	/	NFEC	TION	/		_	24a. Was an autopsy perform		4b. Were aut prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
<b>=</b>	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:		700	-52.00	Oth			Check only one			
	Attending Phys ir death. ector: After this by the funeral dii	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☑ Inpatier 28a. Date of Injur (Month, Day	y 2	PVOutpation 28b. Time of Injury		: Injury a Work?	4 🗆 Nurs	28	e 5 Resider			fy)
		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc	. (Specify)						City or Town,	State)		al Route Number,
	To the Hospital or within 24 hours efft To the Funarel Discompletely filled in	Medical	one)	rsician: To the best of iner: On the basis of and manner star	examination	rledge, death on and/or inv	estigation, ir	n my opin	ion, death	place, an occurred	at the time, da	te and pla	ice, and due t	o the cause(s)
)	(A)		29b. Signature and title of certifier	ant.T	10	MO	I	License n	2600	515	-	9/2	igned (Month,	
	792		30. Name and address of person who o	A 614 A	SEM	STERA	Print) V <i>S</i> //	ME	DI		SALISDO	OKY	1	10 21824.
	Sta Registra	ie ar	31. Date filed (Month, Day, Year) SEP 0 6 21	32. Algistra	s signatu	K Son	aster							,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 State State Registrar #1 per Dr/wichd/9-14-06/dls Certificate of Death Amend item 1-1. Decedent's Name (First, Middle, Last)
Hedges 2. Date of Death **Physician** 14:08 M Catherine Fuller Barker 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Home 5145B4K4 PENINSULA REGIONAL MEDICAL CEMPA 5. Social Security Number If Under 1 Year | Il Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Min Director 124-20-3927 81 4/23/1925 Missouri Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28e-1 show traumatic event, it a Madicul Examinating the notified at 1 ☐ Yes 2X No Maryland Wicomico Salisbury Directo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1002 Beaglin Park Dr., Apt. 101 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: white Specify: δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Robert Lee Hedges Catherine Lautz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ie m eny injury or other traum once. Catherine B. Livingston/daughter 28083 Van Tassel Way, Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Mt. Hebron Cemetery 9/8/06 4 ☐ Donation 5 ☐ Other (Specify) Montclair, NJ 21. Signature of Funeral Service Licensee 22 Molloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Varie A. CESP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebra /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of) been signed by the attending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records. 200 3 Probably 4 □Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' this certificate 1 ☐ Yes 2\\ Vital Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( (Specify) \) 1 ☐ Yes 2 No ٢ 1 Umpatient 2 ☐ ER/Outpatient 3 ☐ DOA o After this 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. nerel Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after ö To the Hospital within 24 hours a To the Funerel E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. position un 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 31. Date liled (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 6 2006

Shone 3 sistrar's Signature

29d. Date signed (Month, Dey, Year)

			1. Decedent's Name (First, Middle, La	ast)					2. Date of D			3. Time of Death	
	Physici		STANLEY CHARI	LES BRYANT					AUGUS	ST 30	2006	8:50AM M	
	/Medio Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Tow	n, or Location	n of Death	-	4c. Cour	nty of Death		
	E Adiiii		29300 BARTLETT	AVE.		FΔ	STON			9	ALBOT		
	Funeral				(In yrs. last birthda	v) If Under 1 Ye	ar If Unde	er 24 Hrs.	8. Date of B	lirth		lace (State or Foreign	
	Director		218-42-7839	1 <b>X</b> M 2□F	78 Yrs.	Months Da	ys Hours		MAR 4	Day, Year) 1928	ENGL		
			Usual Residence of Decedent						THE T	1,720	DIVOL	MIND	
	/lanc		10a. State 10b. County		10c. City, Town or	Location					1	Od. Inside City Limits	
	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "neturel", or theme 23e or 28e i show event, it e Madical Examiner must be notified.	Funeral Director	MD TALI	вот	EAST	ON						1 TYYes 2 □ No	
	라 타 2.7.28	ire	10e. Street and Number			10f. Zip Cod	le			10g. Citizen o	of What Coun	itry?	
	th wil	alD	29300 BARTLETT	AVE.			21601			1	J.K.		
	deat	ner	11. Marital Status	12. Was Decedent E- Armed Forces?	ver in U.S. 13	If Yes, specify 0	of Hispanic C	Origin? (Spec	cify Yes or N	lo- 14. R	ace - Americ		
ယ္	after or Ite	Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No					ricari, etc.)		lack, White,	etc.	
8	el', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 <b>%</b>	No <i>Specil</i>	у:		Spec	wH	ITE	
5-0	72 hc	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Oc re kind of work do	cupation	ost of workin	na	16b. Kind of	Business/Ind	dustry	
21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life	. DO NOT use re ALESMAN	tired)			AUTOMOTIVE			
2	filed v Hygie ther t		17. Father's Name (First, Middle, Las			ALESTAN	18 Mot	her's Name	/First Middl	le, Maiden Sum		<u> </u>	
Maryland	ould be f Mental ? arked of	Be					10.14100				amo)		
₹	s 1 and 2 should be f Health and Menta item 27 is marked other treumatic ev	٦ ر	ERNEST F. BRYANT		405.14	WINIFRED WATERS alling Address (Street and Number or Rural Route Number, City or Town, St						2 ()	
Ja	2 sho		19a. Informant's Name/Relationship			20.511						C006)	
	1 and 2 Health em 27 i		MARY T. BRYANT/V	ATLE		OO BARTI				1			
9	000-		20a. Method of Disposition  1 Surial 2 Cremation 3	20b. Place of Dis cemetery, cr	ematory or other	place)	יט	ate	wn, State				
altimore,	Pages ment of ent: If it ury or o		' 4 Donation 5 Dother (Spec		OXFORD	CEMETERY		9/2/2	006	OXFO	RD, MA	RYLAND	
a	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice		1	22. Name and Ad FELLOWS,	Idress of Fac	ility NRFTN	S. NIFL	מוניבו אאזאו	TEDAT E	IOME DA	
<b>m</b>	\$ 0 E 2 9		Joseph M. Osta	wusk. C.FSP.		200 S. H						IONE FA	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused t	he death. Do not e	nter the mode of	dying, such a	as cardiac or	respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final	PILME	Cource	01/						Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	~						TYEMS	
	Examiner												
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):								
	nsit	Examin	cause. Enter Underlying Cause (Disease or injury										
	be execute sician and burial-trans	xai	that initiated events resulting in death) Last	c Due to (or as a	consequence of):								
9	be e ician buris		· ·										
Box 68760,	ete Pe	cian/Medical		d			-						
×	eath certifica attending ph for use as t	/Me	IF FEMALE:	23c. If yes, outcome o	f pregnancy					024 (	2 = t = d = li =		
8	atten atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death						Date of delive Month	Day Year	
o	the de	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	me or death 3	☐ Other (specify	)						
P.0	law requires that the de as been signed by the 2 should be detached	Physic	Part II. Other significant conditions	contributing to death but	not resulting in the	underhing cause	gwen in Par	+1	23e Did	I tobacco use co	intribute to th	e_cause of death?	
Ś	res t signe be c	by	Tattii. Ottor significant conditions	commoding to dealin but	Thou resulting in the	underlying cause	giveiriirai			Yes 2□No	/		
orc	w require been si	ted							'-	Tes ZUNO	3 1977100	ably 4 Donkhown	
S	law r as be 2 sh	ple							24a. Wa	s an 24t		psy findings available npletion of cause of	
of Vital Records,	e 4 e	Completed							per 1 ☐ Yes	formed?	death? 1 ☐ Yes		
ta	siclen: Th certificate rector, pag	0	25. Was case referred to medical				26. Pla	ce of Death	(Check only				
>	Physiclen: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpati	ent 3 DOA	Other: 4 🗆 I	Nursing Hom	ne 5 <b>X</b> Res	sidence 6 □C	ther (Specify	<i>'</i> )	
			27. Manner of Death	28a. Date of Injury		of 28c. I	njury at			how injury occ			
on	트 . 등 늘	atio	1 ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year) Injury		Work? I∐Yes 2.{	□No					
Division	Attending ir death. ector: After by the fune	fice	3 Suicide 6 Could not l	28e. Place of Injur	y - At home, farm,	street, factory, offi	ce	2	28f. Location (Street and Number or Rural Route Number,				
Dİ	⊒ te o	Certification:	4 Homicide	building, etc.	(Specify)	•			City or To	own, State)			
	e Hoepital or Attend 24 hours after death e Funeral Director: /		29a. Certifier 1 ☐ Certifying P	hysicien: To the best of	my knowledge, de	ath occurred at th	e time, date a	and place, a	nd due to the	e cause(s) and i	manner as st	ated.	
	e Hoe 24 h e Fun letely	dical	(Check only 2 Medical Exa	miner: On the basis of and manner state	examination and/or	investigation, in n	ny opinion, de	eath occurre	d at the time	, date and place	e, and due to	the cause(s)	

State Registrar

STANLEY BRYANT

31. Date filed (Month, Day, Year) AUG 3 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



			1 - For AMEND# 15,19a Registrar AACO HEALTH	State of Ma	aryland	/ Depa		t of H	ealth a		ental Hyg	ijene	•	29976
	Physici	an	1. Decedent's Name (First, Middle,	Last)	CMH						2. Date of Dea	th		3. Time of Death
	/Medic	cal	Carole Wallac				4b City	Town or	Location of		Aug.	28 Pay	2006 county of Dea	11:50р м
	Examir	ier	680 Dill Cour						rna P				Anne A	
	Funeral		Social Security Number	S. Sex 7. Ag	e (In yrs. la:		If Under Months		If Under 2		8. Date of Birth (Month, Day	1		thplace (State or Foreign
	Director		213-50-8362 Usual Residence of Decedent	1□M 2⊠F	58	Yrs.								hington, DC
	yland sow		10a. State 10b. County		10c. City,	Town or Lo	cation		<u></u>					10d. toside City Limits
	Ba-f st	ctor	MD Anne	Arundel	,		Seve	rna i	Park	_				1 ☐ Yes 23% No
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28e-f show ent, the Mudical Examinar must be notified at	Funeral Director	10e. Street and Number 680 Dill Cour	t			10f. Zip		146		1	0g. Citize	en ol What Co U	ountry? SA
	tems	uner	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Deced	ent ol Hi	spanic Orig n, Mexican,	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14	Black, Whit	
39	irs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	d 1 ☐ Yes 2 X 1 If Yes, Give Year or Dates:	No		1 ☐ Yes 2	⊠ No	Specify:			3	Specify: V	White
20	72 hou	eted	15. Decedent's (Specify only highest			16a. Deced	dent's Usua kind of wor	I Occupa	ition	of worku	20	16b. Kind	d of Business	/Industry
21215-0036	within ane. Ithen "	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5	5+)	life. I	no not us	e retired,	) -		.9		Freela	nce
0	filed in Hygie other in the	Be Co	17. Father's Name (First, Middle, La	- 4						r's Name	(First, Middle,			
/lan	Menta Menta arked artic ev	ToB	Albert Wallace						Grac	e La	tham			
Maryland	ind 2 sho alth and 27 is mu		19a. Informant's Name/Relationship Allena Sherri E		hter						Route Number Saithers			Zip Code) 20878
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examiliter must be notified at ODGE.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	Barnett    Removal from State	20b. Pla cer Met	ce of Disponetery, crem	esition (Naminatory or ot	e of ther place LY	9)	Sept	. 2		ation - City or imore,	
Balti	permit. Departm Departm Importa any inju		21. Sign ture of Freneral Service Lie			) B	arran 95 Go	Addres V. R	s Sons	. P.	_	rna	Park F	uneral Home
	Physician		23a. Part Enter the disease, or co shock, or heart failure. List or tmmediate Cause (Final disease or condition resulting in death)	omplications that caused hy one cause on each line.			er the mode	ol dying	g, such as o	cardiac o				Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as										YELD
	ted nsit	Examiner	Sequentially list conditions, if any, leading to innegrate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a conseque	rica uf):								
,092	icate be executed physician and s the burial-transit	cal Exa	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):								
687	ficate physics the			d.										
P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. tf yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pre Other (spe					23	d. Date of de Month	ivery Day Year
	w requires that is been signed by should be deta	by	Part II. Other significant condition	s contributing to death b	ut not result	ing in the ur	nderlying ca	iuse give	n in Part I.		23e. Did tol			the cause of death?
Vital Records,	aw requ s been 2 shoul	Completed									24a. Was a	n	24b. Were au	utopsy findings available
<u>~</u>	The law cate has page 2 s	Com									autops perform	ned2 2 No	prior to death? 1 ☐ Yes	completion of cause of
Vita Vita	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	r		(Check only on			
	ding Phys h. After this funeral di		1 Yes 2 No  27. Manner ol Death 1. Naturat 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ry 2	R/Outpatien 8b. Time ol Injury		Bc. Injury Work	at Nur	2	ne 512 Reside 8d. Describe ho			cify)
Division of	l or Attending after death. Director: Aftel In by the fune	Certification;	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determini	t be One Blees of Ini	ury - At hom c. (Specify)	e, Jarm, str					8f. Location (St City or Town	reet and n, State)	Number or Ru	ural Route Number,
_	To the Hospital or Attending Physician: The i within 24 hours alter death.  To the Funeral Director: Atter this certificate hat completely filled in by the funeral director, page	Medicai C	29a. Certifier  (Check only one)  Certifying  2 Medical Ex	Physician: To the best caminer: On the basis of and manner sta	rexaminatio	ledge, death on and/or inv	occurred a vestigation,	at the tim in my op	e, date and inion, death	d place, a	and due to the card at the time, d	ause(s) a ate and p	nd manner as	s stated. e to the cause(s)
	To the within To the comple	₩ W	29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (Mont	h, Day, Year)
				" HA	/		ĺ	200	051.	301	+	1/9	us 2	9 2006
	5		30. Name and address of person of the state	no completed cause of d	eath (Item 2	23a) (Typa, 10 Be	Print) H	EVIV TC	H,	00	FAN	1400	ls a	10 2/40
尺	Sta Registr		31. Date filed (Month, May, Year)	32. Augustr	ar's Signatu	re	Book	0						

DHMH 17 Rev 1/2001

## A CATH PART OF THE PRINTING AND ADDRESS OF THE PART			1 - For State Registrar	State of Ma	aryland		artment of H		Mental Hyg	iene 2	006	29977
A Facility favore (from instance, one water and number)  Shady Grove Adventists Hospital  Shady Grove Adventists Hospital  Shady Grove Adventists Hospital  Rockville  Social Search Shady Grove Adventists Hospital  Rockville  Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  The State Social Search Shady Grove Adventists Hospital  Rockville  The State Social Search Shady Grove Adventists Hospital  The State Social Searc				/		B	.00M		Month	Day		3. Time of Death
Usual Religion of Decaders   Total Carp, Town or Location   Total Residence of Decaders   Total Carp, Town or Location   Total Residence of Decaders   Total Carp, Town or Location   Total Residence of Decaders   Total Carp, Town or Location   Total Residence of Decaders   Total Carp, Town or Location   Total Residence of Decaders   Town or Location	Examir		Shady Grove Adv	entist Hos	pital	st birthday)	Rockvi	11e If Under 24 Hr	rs R Date of Birth	Мо	ontgome	10 /64
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Part   Start and sease of dempilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate intreas Between Shock of heart failure. List driv) one cause on each line.	Director		Usual Residence of Decedent	1□M 2ŒF				Hours Mil	April 2	5,1932		achusetts  Od. Inside City Limits
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Part   Start and sease of dempilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate intreas Between Shock of heart failure. List driv) one cause on each line.	r 28a-f ahd	irector		mery	Ro	ckvil]			1	0g. Citizen	of What Coun	1 ☐ Yes 2 ☑ No
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Part   Start and sease of dempilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate intreas Between Shock of heart failure. List driv) one cause on each line.	after death wit or Iteme 23e o	/ Funeral D	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ N	Ever in U.S		Vas Decedent of H Yes, specify Cuba	ispanic Origin? ( in, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. F	Race - Americ Black, White, o	an Indian,
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Part   Start and sease of dempilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate intreas Between Shock of heart failure. List driv) one cause on each line.	vithin 72 hours ne. hen "neture!",	mpleted by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Year or Dates: Education ade completed)	5+)	16a. Deced (Give life. L	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of w	vorking	16b. Kind of	Cauc f Business/Inc	
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Part   Start and sease of dempilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate intreas Between Shock of heart failure. List driv) one cause on each line.	vuid be filed w Mental Hygier Arked other th	To Be Cor	17. Father's Name (First, Middle, Las	υ		Bus	inesswom	18. Mother's Na				
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Part   Start and sease of dempilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate intreas Between Shock of heart failure. List driv) one cause on each line.	Man 2 sho leelth and 2 mm 27 is man her traums		Leonard M. Bloo			10401	Grosveno		1318; Rock	ville	, MD 2	20852
Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Part   Start and sease of dempilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate intreas Between Shock of heart failure. List driv) one cause on each line.	it. Pages rument of the rument		1 ☐ Burial 2 ☑ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	ify)	cen	Linco	atory or other place In Crema	tory 9/0	05/2006	Bren	twood,	Maryland
Physician (Medical Examiner)    Part   Common	Dep de la constant de		USS. G		the death.	10	40 Rockv	ille Pil	ke; Rockvi	lle,	tion C Maryla	ind 20852
Cause Enter Underlying Character or minury resulting in death Last    Comparison of Comparison or minury resulting in death   Last   Comparison of Comparison or minury resulting in death   Last   Comparison of Comparison or minury resulting in death   Last   Comparison of Comparison or minury resulting in death   Last   Comparison of Comparison or minury resulting in death   Last   Comparison or minury resulting in death   Last   Comparison or minury resulting in the past 12 months?   Comparison of Comparison or minury resulting in the past 12 months?   Comparison of Comparison or minury resulting in the past 12 months?   Comparison of Co	/Medical		Immediate Cause (Final disease or condition	a Resper	ative	a f	4. 1				)	Onset and Death
The control of the		al Examiner	that initiated events	с			itive Pi	ulm v~)	ary /) is	earc		earl
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death   17g Yes   2 no 3 probably 4 plants   17g Yes   2 no 2 no 2 not not not not not not not not not not	the death certificate the attending physiched for use as the		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1⊡Live birth 4⊡Pregnant at	2 Fetal d	leath 3 🗌						•
24a. Was an autopsy findings avail prior to completion of cause death?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28b. Time of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred to finjury  28d. Describe how injury occurred to finjury  28d. Cartifier (Check only office building, etc. (Specify))  28d. Cartifier (Check only one)  28d. Cartifier (Check only office building, etc. (Specify))  28d. Cartifier (Check only office building, etc. (Specify))  28d. Cartifier (Check only office building, etc. (Specify))  28d. Cartifier (Check only one)  28d. Describe how injury occurred to finjury at home, farm, street, factory, office building, etc. (Specify)  28d. Cartifier (Check only one)  28d. Cartifier (Check only office building, etc. (Specify))  28d. Cartifier (Check only one)  28d. Cartifier (Check only one)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Cartifier (Check only one)  28d. Cartifier (Check only one)  28d. Cartifier (Check only one)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Cartifier (Check only one)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Injury: At home, farm, street, factory, office building, etc. (Specify)  28d. Date of Inj	equires thet in signed by ould be detailed	þ	^	. 1			derlying cause give	en in Part I.				
25. Was case referred to medical examiner?	i: The law recate has be		,	1					autops: perforn	ned?	prior to con death?	npletion of cause of
27. Manner of Death   School   Section   Secti	sician certifi rector	00	examiner?	Hospital:		20	Othe			-		
3 Suicide 4 Homicide 5 South A Rall MD (6 220) Freduct (2 and 3) Suicide 4 Homicide 5 South A Rall MD (6 220) Freduct (2 and 3) Suicide 5 South A Rall MD (6 220) Freduct (2 and 3) State  3 Suicide 4 Homicide 5 Could not be determined 5 South A Rall MD (6 220) Freduct (2 and 3) State 5 South A Ra	nding Phy ath. r: After this	-	27. Manner of Death NaNatural 5 ☐ Pending	28a. Date of Injur (Month, Day		8b. Time of	28c. Injun	at				)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Ital or Atta	Certific	4 Homicide determined	building, etc	c. (Specify)				City or Town	, State)		
290. Signature and title of certainer  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)  290. Date signed (Month, Day, Year)	the Hosp hin 24 hou the Funer mpletely fil	Medical	one)	and manner sta	ted.	on and/or inv	estigation, in my op	oinion, death occ	curred at the time, da	ite and place	e, and due to	the cause(s)
JOSEPH A BAIL MD 16220 Frederick (2-0d #213 6Athersby MD 20)  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	20	_	Doen AB	oll my	- Ab //4 -	220) 77	D ST	3317	A	Lug u	1 29	2016
State GED OR 2006 A. A. A. A. A. A. A. A. A. A. A. A. A.	Sta	te	JOSEPH A T	32. Registri	eath (Item 2 <b>6</b> 22 car's Signatu	(Type, I	derick (	Sand?	#213 6A	the	iby	mo 20177

			1 - State o	f Maryland / Dep Co	partment of F e <i>rtificate of</i> .	lealth and N <i>Death</i>	lental Hyوب ۴	giene 2006	29978
	Physici /Medic		Decedent's Name (First, Middle, Last)     Samuel Berman				2. Date of Dea Month Septemb	Day Year	3. Time of Death 6:05 A.M
	Examir Funeral		4a. Facility Name (If not institution, give street and nur Suburban Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Betheso	r Location of Death  a it Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 1	4c. County of Death Montgome 9. Birth Year	
	Director Move show	-	100-10-5931  Usual Residence of Decedent  10a. State 10b. County	95 Yrs.  10c. City, Town or Chevy Ch			reb. 1.	1, 1911 Nev	10d. Inside City Limits
	with the Manager 1 and 1	Funeral Director	Maryland Montgomery  10e. Street and Number  9 West Kirke Street	Cirevy Cir	10f. Zip Code	815		10g. Citizen of What Cou	14∑Yes 2 ☐ No intry?
036	within 72 hours after death with the Maryland ene. Then "naturel", or Iteme 23a or 28a-f show ta Madical Examinar must be notified at	by	11. Marital Status  1 Never Married 2 Married 1 Yes, Giv Year or D.	2 (2) No	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	be filed within 72 hours after death with the Manylan dai Hygiene. An Other then "naturel", or Iteme 23s or 28s-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	(Giv	cedent's Usual Occup ve kind of work done of DO NOT use retired	ation during most of work 1)	-	16b. Kind ot Business/Ir	
Maryland 21	should be filed within of Mental Hygiene. marked other then marked other then matic event, the Mental control of the Mental control	To Be C	17. Father's Name (First, Middle, Last)  Nathan Berman			Rose	e (First, Middle, Wollman	Maiden Surname)	
e, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny injury people reaumatic evone.		19a. Informant's Name/Relationship (Type, Print)  Sandra Ratner - Daughter  20a. Method of Disposition		est Kirke	Street, (	Chevy Ch		0815
altimore,	artment of lortent: If Its		1 Burial 2 Cremation 3 Removal from 3 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	State Cemetery, cr	Moses	Sept.	7, 200		, New York
Ra	Dep.		1000	timur	1170 Rocky	ille Pike	. Rockv	1 Chapels, ille, Maryl	and 20852 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a.	or as a consequence of):	preum	^			Interval Between Onset and Death
	icate be executed XX physician and XX s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (	or as a consequence of):  Or as a consequence of):  Or get the	obsta Hean	verne j - tai	Pulmon	any Jisara	
. Box	ath certif ittending or use a	by Physician/Medical	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)	<i>U</i>		23d. Date of deliv	ery Day Year
ecords, P	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions contributing to de	- 0	underlying cause give	en in Part I.	23e. Did tol	pacco use contribute to t	he cause of death?
<u> </u>	The ete h	Completed	Chronic O rona Diabetes	e O Queit	en TO		24a. Was a autops perform	y prior to co	opsy tindings available impletion of cause of 2□ No
sion or vital	ng Phys fter this meral di	ation: To Be	27. Manner of Death  □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□	npatient 2 ER/Outpatie of Injury 28b. Time h, Day Year) Injury	of 28c Injury Work	4 LI Nursing Ho	me 5 ☐ Reside	e)  ance 6 Other (Special ow injury occurred	(y)
DIVISION	ital or Attaurs after de rel Directo	Certification:	4 Homicide Suildir	of Injury - At home, farm, s ng, etc. <i>(Specify)</i>			City or Towr		
•	To the Hospital or Attending Ph within 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  20 Medical Examiner: On the ba and mann  29b. Signature and the of certifier	isis of examination and/or i	ath occurred at the tim nvestigation, in my or 29c. License	oinion, death occurr	ed at the time, d	ause(s) and manner as sate and place, and due to get the signed (Month,	o the cause(s)
)	6		1 Happen	e of death (Item, 23a) (Type	D5	3691		Sept.5	2006,
	Sta Registra		30. Name and address of lerso who completed cause  31. Date filed (Month, Day) Year)  32. Per complete cause  33. Date filed (Month, Day) Year)  34. Date filed (Month, Day) Year)	egistrar's Signature	Democo	J 1510	7, 15	on a,	1410 20817

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006.

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			for State	State	n iviai yiai	riu / Depa	rtificate of	nealltí ar Death	iu ivientai m		_000	- C. J.	, , ,
			Registrar     Decedent's Name (First, Middle, La	st)		061	incate of	Death	2. Date of D	Reg. No.		3. Time of I	Death
72	Physici			ter Ell	is Bai	nes			Month	Day	2 2006	1058	A <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, given			iieb	4b. City, Town, o	or Location of I			ounty of Deat		
E.			Union Hospital				E1kton			C	eci1		
No.	Funeral	1	Social Security Number     6. S		7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24	Min. (Month, L	irth Jay, Year)	9. Birti Co	hplace (State or	Foreign
	Director		240-32-2193	M 2□F	78	Yrs.			March 2	2, 1928	Nor	th Caro	lina
	land		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City	y Limits
	Mary Inc	ţŏ	Maryland Cecil		, n	North E	ast					1 ∰ Yes	2 □ No
	r 288	Directo	10e. Street and Number		*	TOT CIT I	10f. Zip Code			10g. Citize	en of What Co	ountry?	
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	dea a	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decedent of I	Hispanic Originan, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	10- 14	4. Race - Ame Black, White		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖫 Divorced	1 ☐ Yes If Yes, G Year or I	ve		1 ☐ Yes 2 ☑ No	Specify:			Specify: Wh		
Maryland 21215-0036	within 72 hours after death with the Maryland ane. then "netural", or items 23s or 28s-f ehow the Marical Examiner must be notified at	edt	15. Decedent's E		Ales:		dent's Usual Occup	pation		1	d of Business/		
212	hin 72 n "ne Mediiy	piet	(Specify only highest gr. Elementary/Secondary (0-12)	de completed) College (	1-40(5+)	(Give	kind of work done DO NOT use retire	during most o	f working	i ob. italic	7 01 003111033	modstry	
7	filed with Hygiene other the	Completed	12		1-401 5+7	Car	penter			Co	nstruc	tion	
p	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last	)				18. Mother's	Name (First, Middl	e, Maiden S	umame)		
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "netural", or items 23a or 28a-f ehow aumatic event, the Madical Examiner count be notified at	ို	William Baines						a Stephens				
Mai	ages 1 and 2 should b nt of Health and Ment: : If Item 27 Is marked : or other traumatic e		19a Informant's Name/Relationship ( Shirley J. Fitzwa						or Rural Route Num			, , , ,	
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OL.	Pages nent of nnt: If Its ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Con				natory or other pla	1	ptember , 2006	West	t Chest	er,	
Baltimore,	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Lice		IN • P.	rerris	& Co. Inc.		unerals,	Pent	nsy1var	iia	-
m			Buister His	by Cri	mer	10	OS W. Sto	ckton	unerais, Street, E	P.A. 1kton.	Marv1	and 219	21
*			23a. Part . Enter the disease, or com- shock, or heart failure. List only	plications that	caused the dea							Approximate Interval Betw	
il.	Physician		Immediate Cause (Final disease or condition	. Non	smal	1 cell	Carcino	ma ot	the lui	19		Onset and De	eath
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90 100	eath certific attending p I for use as 1	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live I	tcome of pregn pirth 2 Fet	al death 3	Ectopic pregnanc	у		23	d. Date of deli	*	ear
P.O. Box	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregi 9□ Unkn	nant at time of own	death 5∟	Other (specify) _					54,	
	that i	y Ph	Part II. Other significant conditions	ontributing to d	eath but not re	sutting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco use	contribute to	the cause of de	ath?
rds	quires n sign	q p	Atrial fibrillation	with	rup.d i	rentricu	lar respo	nse		Yes 2□	No 3 ☐ Pro	obably 4 Ur	nknown
ပ္တ	aw requires s been si 2 should l	piet					/		24a. Wa		24b. Were au	topsy findings av	vailable
Ĭ	The lav	Completed by								opsy ormed? 2.Σ€No	death?	completion of cau 2 No	1se of
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5	Physi this c al dire	2	1 ☐ Yes 2 No			ER/Outpatien		4 🗀 Nursi	ng Home 5 ☐ Res			cify)	
Division of	ding I	lon	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio	1	th, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe	how injury o	occurred		
<u> </u>	Atten deat ctor: y the	fica	3 Suicide 6 Could not b	e 28e. Place	of Injury - At h	nome, farm, str	eet, factory, office	163 2 110		(Street and I	Number or Ru	ral Route Numbe	er.
Š	al or / s after il Dire	Certification:	4  Homicide determined	build	ing, etc. (Speci	ify)			City or To	wn, State)		a riodio ridino	
	To the Hospital or Attending Physicien: within 24 hours after deals. To the Funeral Director: After this certifical completely filled in by the funeral director; p		29a. Certifier 1 Certifying Pt	ysician: To the	best of my kn	owledge, death	occurred at the tir	ne, date and p	place, and due to the occurred at the time	cause(s) ar	nd manner as	stated.	
	the H hin 24 the F hplete	Medical	0/16/	and man	ner stated.	ation and of in			occurred at the time				
l	To To	-	29b. Signature and title of certifier	Que la	115	)	29c. Licens	53675			signed (Month 3/06		
	-1		30. Name and address of person who					7 20 73		( ) (	3/06		
J	3		Robert A. Mon	televas	, MA	/// W.	High S	t. Suite	214 El	Kyon	MO	21921	
	Sta		Robert A. Mon. 31. Date filed (Month, Day, Year) SEP 2 0 2	32.	legistrar's Sign	atute	sell)		./				
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State of Maryland / Department of Health and Mental Hygien 2006 29980 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SHU-CHEN SEPT. 1:15р м CHANG 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB - 8, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 214-92-7829 1 ☐ M 2 X F 94 Yrs. Director CHINA Usual Residence of Decedent the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits or then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MONTGOMERY ROCKVILLE MD. Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 death with 20850 9701 -VEIRS DRIVE USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: CHINESE ģ 3X Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Importent: If item 27 is marked other then " eny highy or other treumetic event, tre Mage. 2008. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER AT HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WEN-LUA CHANG SHIH CHANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Para, Pouls 1900) 14700 - SILVERSTONE DR., SILVER SPRING, MD. YUN-CHI LU -SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METROPOLITAN CREM. 9/8/2006 ALEXANDRIA, VA. d ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HYSONG CO., INC. 21. Signature of Funeral Service Licenses CC0367 2222-WISCONSIN AVE., NW, WASH., DC 23a. Part1. Enter the disease, or c shock, or heart failure. List of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ADVANCED HETASTATIC CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physician and thed for use as the burial-transit be executed resulting in death) Last Due to (or as a consequence of): Box 68760 ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No Division of Vital 1 Yes 2 🔼 No 1 TYes Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 🔊 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 🗌 Yes this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel ( Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Whenthe Bulling 2006 DO051158 SEPTEMBER 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701 ROCKUILLE M.D 20850 VEIRC DRIVE AN DHO NY VATTITI 31. Date filed (Month, Day, Year) State 2006

DHMH 17 Rev 1/2001

2998 State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** hirLENE 20:44 08 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edward McCready Memorial Hospital
mber 6. Sex 7. Age (In yrs. last birthday) risfield 1 Year | If Under 24 20Merse T 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 N 63 Yrs. Months Days Hours 141-32-4118 MD Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic event, the Middlest Examinar must be nutified at 10d. Inside City Limits MD Jonesse-1 **∑**≪es 2 □ No Director e 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -1817 Road Way Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kubberset 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Williams Inc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HEnry Ed:4h orney William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is eny Injury or other tra-Broad way James Collins Hus band 2181 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Lecation - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State elevan Comedery 09-11-06 4 ☐ Donation 5 ☐ Other (Specify) Turlock 21. Signature of Funeral Service Licensee 22. Name and Address of Facility -uneral Home Cristicid, UD 80 (vere 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONGES TIVE yerm disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certiticate be executed within 24 hours atter death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Recent 2 🗆 No 3 Probably Completed 4 []Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 2 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1- Natural 5 Pending investigation Injury satter de. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the true, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39813 30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) , Mr) 2(817 Michael Atkins CRishelel 201 USE U 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 29982 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Q **Physician** James A. Coulbourne 2006 10:05P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Berlin Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5 13 9. Birthplace (State or Foreign **Funeral** Year 1925 1√2 M 2□ F Months Days Hours Min 81 221-12-8577 Yrs. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☑ No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 65 Ocean Parkway 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 12 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Navy Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: White 3X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alonzo Coulbourne Sr. Alice Cole ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Coulbourne (son) 65 Ocean Parkway, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pittsville Cem 9/10/2006 Pittsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundial Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Hura 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one car is on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed nding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s has been signed bige 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2/2 No certificete 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes >2 ☐ No ဥ 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 10 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funerel Dire 4 Thomicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Crieck unity one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 1209 Exestal Agling Flewit Isbed De 19944 BA 4 + 1 NICLEOLAS 31. Date filed (Month, Day, Year) SEP 0 8 egistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 1 2006 8:20 PM /Medical CLINGAN SHIRLEY IRENE 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Sept. Director 213-40-6708 30. 1944 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at Director MD Frederick 1 ☐ Yes 2X No Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4406 Teen Barnes Rd. 21755 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TNo Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: if item 27 ie marked other then 'any injury or other traumatic event, tra Ma Elementary/Secondary (0-12) College (1-4or 5+) electronics co-owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Crouse Mary Ramsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Clingan (Husband) 4406 Teen Barnes Rd., Jefferson, MD 21755 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 9/5%06 20a. Method of Disposition 20c. Location - City or Town, State MCMBurial 3 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Senature of Fineral Service: Icensee Middletown, MD Locust Valley Cemetery <sup>2</sup>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, where the disease of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** preumenti du to preumegisti /Medical Due to (or as a consequence of): Examiner hanchih Bhunhi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the daath certificate be executed -transit Due to (or as a consequence of and attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ cate has been sig , page 2 should b 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3√ No 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury To the note that death, within 24 hours efter death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 GRISSOM MNEY MEDELJOK 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 Registrar

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DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		ent of Health and ate of Death	Mental Hygier	2005	29985
	Physici /Medio	al	1. Decedent's Name (First, Middle, Las	CAMP	bell	Sity, Town, or Location of Dea	September	3. 2006	3. Time of Death 2:15 p M
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	ath with the Is 23a or 28a-	by Funeral Director	Maryland Inface 6  100. Street and Number  8600 Mike Sh	apiro Dr. Apt	+ 1013 B	Zip Code 2 4 7 3 5 -		Citizen of What Coul	ntry?
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Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other ance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Fuheral Service License)	St.	MARYS O	and Address of Facility	2/06 Pp	pontown	H)
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30,	rate be executed hysician and the burial-transit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o s a conse y c. Due to (or as a conse qu	pence of):	infest			2 well
Box 68760,		n/Medical	IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcome of pregna				23d. Date of delive	
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Records,	w requires that been signed I should be det	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlyin	ig cause given in Part I.	23e. Did tobacco	use contribute to the	ably 4 Unknown
	ysician: The law is certificate has b director, page 2 s	e Completed	25. Was case referred to medical			00 81-2-41	24a. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of 2 No
Division of Vital	ding Ph h. After th funeral	ation: To Be	examiner?  1 Yes 2 No  27 Mayner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	Oth	ath Check only one dome 5 Residence 28d. Describe how in		()
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	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	sician: To the best of my knowiner: On the basis of examinat and manner stated.	tion and/or investigati	ed at the time, date and place ion, in my opinion, death occu	irred at the time, date ar	nd place, and due to	the cause(s)
2	¥ 3 7 8		1 San	$\sqrt{2}M$	9	D-2453		ate signed (Month,	- /
	) Sta	(e	30. Name and address of person who con Laxmi Berwa, MD 31. Date filed (Month, Day, Year)	7700 Old Bran	ch Ave. (	Clinton, Maryl	land 20735		
	Registr		SEP 0 7 7	2006 Streve	1. Spark	E Common of the			

Reg. No. 2006 29986 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Bennett Crain September 3, 2006 Рм 1:53 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min. 1⊠M 2□F 75 212-36-2090 Yrs. Director 1, 1930 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Exertitive must be notified at Anne Arundel Yes 2 □ No Ft. Laudendale Florida Broward Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 33316<sup>401</sup> Court U.S.A. 1649 SE 13th St. death Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1⊠Yes 2□No If Yes, Give Year or Dates:KOrea tams 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2X Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify. ρ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Lawyer Law permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygie. Important: If item 27 is marked other tt any injury or other traumatic avent, III.e. Once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bennett Crain Helen Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Crain/wife 6 Cumberland Court Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 9/6/2006 Baltimore, Maryland 21. Signature I Fineral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a contequence of) **Examiner** Sequentially list conditions, it any, leading to limitediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2□ No 1 ☐ Yes 2 17 No 1 Yes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 🗀 es 2 🗆 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ို 1 🗹 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 
Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/ completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

6 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 05, 2006 SEPTEMBER Ellene Boerner Christiansen 10:22 AM /Medical 4a. Eacility Name (If got institution, give street and number) Saint Joseph Medical Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 M 2 F Days 220-30-5542 Director 08/13/1933 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Mudical Examiner must be notified at Director MD Baltimore 1 Yes 2 No Freeland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 238 20830 Millers Mill Road 21053 USA Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after Hygiene. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 # No δ Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainmeth. Elementary/Secondary (0-12) College (1-4or 5+) 4 Free Lance Artist Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chris Christiansen Cathrine Boerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Richard Frye-Husband 20830 Millers Mill Rd. Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation 09/06/06 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee Steven W. Elin M00723 934 South Main Street Hampstead MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOPULMONARY ARREST **Physician** HOUR /Medical Due to (or as a consequence of):
MUSCULAR DYSTROPHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 🗌 Yes 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 21XNo ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 18canna D0062312 09-05-2006 wit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCOTT BRANNAN, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. pegistrar's Signature State Registrar SEP 0 7 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 2 2

			1 - For State Registrar	State of Ma	aryland / D	epartmer Certificat	e of De	aith and M eath	lental Hyg	eg. No. 200	6 29988
	Physici /Medic		Decedent's Name (First, Middle, La	(st)	(0)	VDE			2. Date of Dea Month	th Day Year 30 Zod	1011011
	Examir		4a. Facility Name (If not institution, gir Washington Adventi			4b. City,		cation of Death		4c. County of De	eath
	Funeral Director		5. Social Security Number 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6.		e (In yrs. last birth			Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) October 1	Montgo (Year) 9. B (5, 1945 E1	mery  inthplace (State or Foreign Country)  L Salvador
	ryland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f ehow rimust be notified at	Director	Maryland Montgom  10e. Street and Number	ery		Silver S					1 □ Yes 2√No
	3a or 3		1005 Merrimax Dri	ve		10f. Zip		903	'	0g. Citizen of What (	,
õ	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene the Health and Mental Hygiene tems 23a or 28a-f ehow them traumatic event, the Medical Exercities must be notified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give		13. Was Dece If Yes, spe	dent of Hispa orfy Cuban, N	nic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
2-003p	hours fural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	162	Decedent's Usu		E1 Sa	lvadorian	Specify: 16b. Kind of Busines	White
CLZLZ	l within 72 iene. r than "na Ine Medic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	(	'Give kind of wo life. DO NOT u	rk doné durin	ng most of workir	ng	Domestic	,
/land /	al Hyg	BeC	17. Father's Name (First, Middle, Las	)	<u> </u>	1101116		. Mother's Name	(First, Middle, I	Maiden Sumame)	
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Z Z	lith and 27 is not traun		19a. Informant's Name/Relationship Elias G. Conde - S							. City or Town, State, .ifornia 9574	
nore,	0 = 50		20a. Method of Disposition  1 X Burial 2 Cremation 3 [ 4 Donation 5 Other (Speci	Removal from State	20b. Place of I cemetery	Disposition (Nar , crematory or c	ne of ther place)	D	ate	20c. Location - City of	or Town, Slate
Бащтог	permit. Pages Department of Important: If it ony injury or once.		21. Signature of Funeral Service Lice		George W	ashingtor 22. Name ar				Adel hi, Man i Funeral Ho	
			23a. Part1. Enter the discusse, or comshock, or had salled a List only	aplications that caused one cause on each lin	the death. Do no	ot enter the mod	e of dying, si	uch as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Use to (or as a	a consequence of	).					
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		Bec	25. Was case referred to medical examiner?					. Place of Death		9/	
	ding Physician; 1. Alter this certific, funeral director,	ion: To	1 Yes 2 No  27. Manner of Death 1-Natural 5 Pending	Hospital: 1 Inpatier  28a. Date of Injuny (Month, Day)		ne of ury M	8c. Injury at Work?	2		nce 6 □Other (Sp w injury occurred	ecify)
DIVISI	To the Hospital or Attending Phywithin 24 hours eiter death. To the Funeral Director, Alter thi completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	OB Place of Lain	ry - At home, farn . (Specify)			2 No 2	8f. Location (Sti City or Town	reet and Number or F , State)	Rural Route Number,
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	To th within To th comp	Me	29b. Signature and little of certified		11		. License nui		29	9d. Date signed (Mor	nthy Day, Year)
,-	t		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)	5 2	05		5/30/0	2006
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			1 - State Amend Items	State of Marylan <b>25,27,28a-f</b> p	d/Depa er <b>M</b>	artment of H	ealth and <b>20/06dh</b> l	Mental Hyg b	giene Reg. No. 200	6 29989
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medic		John Wallace Cha	nce				Month Sept	9 200	9:25 P M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of De	ath	4c. County of	Death
			Ruxton Health of			Dentor			21629	
	Funeral Director		220-01-9783	M 2□ F 7. Age (In yrs. 93	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year) 9. 1912 M	Birthplace (State or Foreign Country)  [aryland]
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl	ō	Maryland Caroline		Denton					1 Tyes 2 No
	1 the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumette event, the Medical Event har must be notified at Once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Black, 1	American Indian, White, etc. White
Maryland 21215-0036	within 72 ho one. ihan "natur is Medical	Completed	15. Decedent's Educ (Specify only highest grade		(Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired k driver	turing most of w	vorking	16b. Kind of Busin	County Roads
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ylano	nould be to marked or matic eve	To Be	John Lee Chance	- Crist	40b 14cille	Address (Street	Annie	e Matilda	Pinder C	
Na Na	12 sh h and 7 is n treun		19a. Informant's Name/Relationship (Ty) Louis C. Andrew/ n			-		Rural Route Number Denton,		
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Baltimore,	permit. P Departme Importeni any injury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		F 22	Name and Addres	s of Eacility	enbein Fu	neral Hom	e. PA
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	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	JASC uence of):	ular :	accid	ent /	$\mathcal{M}$	Interval Between Onset and Death
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	To the within 2. To the f	ž	29b. Signature and title of certifier	NV.	-	29c. License			29d. Date signed (A	1 .
			= 7	MM	MP	000	4753	34	9/1	1/06
			30. Name and address of person who co							
			Wafik Zaki, MD 92			enton, Ma	ryland	21629		
	Sta Registi		31. Date filed (Month, Day Year) ] ]	2005 Registrar's Signa	ture	forde				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29990 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year James R. Chamberlain Sept. 2006 5:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Nrusing & Rehab. Center Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXXM 2□F Months Director Yrs. Oct. 17, 1940 578<u>-</u>84-2737 Washington, DC Usual Residence of Decedent 10a State or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Directo Maryland Morningside XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23s or the Medical Examiner must be 20746 4603 Morgan Road USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: 1 ☐ Yes 200 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled None other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f nd Mental I marked of Arthur Andrew Chamberlain Maye B. Ward ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 f Sandra Mickey / Sister 4603 Morgan Road Morgangside, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or one 09/12/2006 Suitland, Maryland 4 □Donation 5 □Other (Specify) Cedar Hill Cemetery 21. Signature of praise License 22. Name and Address of Facility George P. Kalas Funeral Home PA 1100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CANCER LARYNX 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★☆Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete has I autopsy performed? 1□ Yes XXXNo of Vital Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2**/∑**XNo 1 Inpatient 2 ER/Outpatient 3 DOA this : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation el or Attendir s after death. nerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospitel To the Hospitel within 24 hours a To the Funerel I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45365 09-07-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD11701 Livingston Road #101 Ft. Washington, Maryland 20744 Michael Sidarous

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

7		For State Registrar  1. Decedent's Name (First, N	iddle, Last)	State of	Marylar	nd / Depa <i>Ce</i>	artment of F	dealth ar Death	nd Mer	ntal Hygie Reg	ene No.200		999 Time of Death			
Physicia /Medic Examine	al er	Bernice 4a. Facility Name (If not instit	End La	reet and num	ber)	heak	4b. City, Town, o	l		Month O - 1	4c. County of Allegan	Death	I:ISA M			
Funeral Director		5. Social Security Number 218-40-6729 Usual Residence of Deceden		M 2√ F	Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days		Min. 8.	Date of Birth (Month, Day, ) (Ay 18,	1943	9. Birthplace Count	(State or Foreign			
e Marylan 3a-f show tilled at	ctor	MD 10b. Co	egany		10c. G	Oldto							nside City Limits ☐ Yes			
h with th	ai Dire	10e. Street and Number 16801 Trails	End La	ine			10f. Zip Code	21555		109	g. Citizen of Wh USA					
JIS 3	d by Funeral Director	11. Marital Status  1 Never Married 2  3 Widowed 4 Divo	Married	2. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	es?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origii an, Mexican, I Specify:	n? (Specify Puerto Ric	y Yes or No- an, etc.)		American In White, etc. <b>white</b>	dian,			
within 72 h ene. then "natu	Completed	15. Dece (Specify only hi Elementary/Secondary (0- 12		ation completed) College (1-	4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most o d)	of working		ospital	iness/Industry	/			
ould be filed v I Mental Hygie varked other t	To Be Co	17. Father's Name (First, Mic		Piper		rogiote	nou nui o	18. Mother's		irst, Middle, Ma	aiden Sumame) Litchie Pl					
1 and 2 should be Health and Mental Om 27 Is marked of ther treumatic ov		19a. Informant's Name/Relate Charles Chea		e, Print) SOI	1	19b. Mailii <b>26</b> V	ng Address <i>(Street</i> Vest Midd	and Number lle Grov	or Rural R Ve Ct.	Westm	City or Town, Si inster	MD 2	1157			
permit. Pages 1 and Department of Health Important: If item 27 Important or other tr		20a. Method of Disposition  1  Burial 2  Cremat  4  Donation 5  Other		moval from S		cemetery, crea	osition (Name of matory or other plan neral Home	<sup>сө)</sup> e, Р.А	9/1		Cresapton - C		MD			
permit. Depart Import any inj	-	21. Signature of Funeral Ser	10	TIM	M		•	ginia Ave	enue: C	Cumberla	nd, MD 2		roximate			
Bath certificate be executed attending physician and for use as the burial-transit	ical Examiner	ical Exa	ical Exa	ical Exa	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c. d.	Due to (c	ch line.	quence of):	•					inte	rval Batween et and Death MONT
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1  Yes 2 No 9  Unknown	23		th 2 ☐ Fetant at time of o	aldeath 3[	Ectopic pregnancy	у			23d. Date Month	,	Year			
w requires that been signed b should be deta	P	Part II. Other significant cor	ditions cont	ributing to dea	ath but not re	sulting in the u	nderlying cause giv	ven in Part I.	a se company of the c		cco use contrib					
	Completed									24a. Was an autopsy performe	od? de: ✓ No 1 □	ere autopsy fi or to complet ath? Yes 2	ndings availablion of cause of			
	Certification: To Be	E _ Nooldon	Ho	28a. Date of (Month)	Injury , Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor M 1	ner: 4 □ Nurs	ing Home 28d	. Describe how	ce 6 Other	1				
To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral		4 Homicide de	ermined	buildin	g, etc. (Speci	owledua deal	reet, factory, office	ma, date mid	ulaca arid	City or Town,	es(e) and marr	oar as stated	8			
To the Ho within 24 f	Medical	29b. Signature and title of ce	tifier	er: On the bar	sis of examin er stated.	ation and/or in	vestigation, in my c	opinion, death	occurred	at the time, date	e and place, and Date signed (EPRM)	d due to the	VI			
17		VIRGINIA	MAG	BOJUS	M	m 23a) (Type,	Print) PETO	N DI	rivi	-, cui	n Bin.	AND	MD 21			
Sta Registra	4	31. Date filed (Month, Day, )	9ar) 2 1 20		gistrar's Sign	ature	falls,									

			For State Registrar	State of Mary		artment of H			ene2006	5 29992
	Dhamini		1. Decedent's Name (First, Middle,	Last)				2. Date of Death	1	3. Time of Death
	Physici /Medio		Hazel Ruth	Dyke	s			August		9:32PM M
	Examir	ıer	4a. Facility Name (If not institution,			4b. City, Town, or	Location of Dea	th	4c. County of De	eath
			9288 Hickory Mil 5. Social Security Number 6		yrs. last birthday)	Salish	oury If Under 24 Hrs	8. Date of Birth	Wicom	
	Funeral Director		214-60-9517	1□ M 2 X F 85		Months Days	Hours Min			Sirthplace (State or Foreign Country)
	p		Usual Residence of Decedent					10-00-1	920   Ma	ryland
	show	7	10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits 1 MYes 2 □ No
	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or Hems 23a or 28a-f show avant. The Medical Exarting must be notified at	Director	MD Wicomi	co	Salisbur	y 10f. Zip Code		145	- 00° - 100°	
	with Ba or			:11- D1			0.01		g. Citizen of What	Country?
	death ms 2;	Funerai	9288 Hickory M	12. Was Decedent Ever	in U.S. 13.	218 Was Decedent of Hill If Yes, specify Cuba		Specify Yes or No-	USA 14. Race - An	nerican Indian,
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo				to Rican, etc.)	Black, W	nite, etc.
003	ural',	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2ØNo	Specify:		Specify:	hite
15-	"nati	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa kind of work done o DO NOT use retired.	lurina most of wo	orking 1	6b. Kind of Busines	ss/Industry
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9	e filed withln If Hygiene. other than	Be C	17. Father's Name (First, Middle, La	none st)	поше	maker	18. Mother's Na	me (First, Middle, M	Own Home laiden Sumame)	
<u>la</u>	Mental Mental arked c	ToB	Charles W. Gibb	ons			Maude I:	rene Brewe	er	
Maryland 21215-0036	2 should be and Mental Is marked (sumatic av		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or R	ural Route Number,	City or Town, State	, Zip Code)
	5 E C =		Robyn Dykes Zwe					Drive, Sai	lisbury,	MD 21804
Baltimore,	ges 1 and 2 should it of Health and Mer If Itam 27 is marke or other traumatic		20a. Method of Disposition  1 Surial 2 Cremation 3	☐Removal from State	Ob. Place of Dispo cemetery, crei	sition (Name of matory or other place	θ)	Date 2	Oc. Location - City of	or Town, State
Ë	t. Partmen rtant:		`4 □Donation 5 □ Other (Spe	cify)				01-2006 We	est Post	Office, MD
Bal	permit. Pages 1 an Department of Heal Important: If Itam 2 any Injury or othar once.	(	Signature of Euneral Service Lic	' /	or Hi	. Name and Addres nman Fune	ral Home	e		
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	PINTER	(	shock, or heart failure. List on mmediate Cause (Final	ly one cause on each line.	11 5/0	- No. 10	9, 02011 40 021 414	o or roophatory arre-	ot,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a cor	rsequence of):	DXIA.				-
	Examiner			PNE	11220	a .				
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	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	cate be executed physicien and the burial-transit	E	resulting in death) Last	Due to (or as a cor	nsequence of):					
87	physi the t	dicai		d						
9 xc	The law requires that the death certifi tie has been signed by the attending i cage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy				23d. Date of d	olivan
Вох	death a atter d for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	that the de ed by the a detached t	hys	9 Unknown	9□ Unknown						
S,	res tha igned be det	by P	Part II. Other significant conditions	contributing to death but not	t resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records,	w require been si should b	ted	<u> </u>	IA				1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown
ecc	e law r has be ge 2 sh	Completed	USTEDPOPOSI	S				24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
-		Con						perform	ed? death? No 1□Ye	10-10
Vital	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho		ath (Check only one	,	#\$£7(1ED)
o	Phys r this ral dii	7	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	113	4 Chansing I	lome 5 Residen		ecify) LI VIIVLY
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ā	s afte	Certification:	4  Homicide determine	building, etc. (Sp	oecity)			City or Town,	State)	
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	To the within To the comp	Me	29b. Signature and title of certifier			29c. License			d. Date signed (Mor	*
			Malust	wit	MO	D-0	00603	15 8	7/30/06	
			30. Name and address of person wh	# A 4 4	(Item 23a) (Type,	Print)			1-1-	MD 21804
			M. HIMMOTEL		6/4/	S ENSTE	EKN SH	ORE DK.	SALISBURY	MD 21804
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		•	For State Registrar	State of Maryl	and / Depa	artment of H	ealth and Death		giene Reg. No. 200	16 29993
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Las Marie M.      Marie M.      Fecility Name (If not institution, give	Danzi	1 !	4b. City, Town, or	Location of De	2. Date of Dea	_	
	Funeral Director		370-20-9937		vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	fs. 8. Date of Birth in. 9/22/19	9.	Birthplace (State or Foreign Country) Shington, DC
	within 72 hours after death with the Maryland ene. then "nature!, or items 23s or 28s-1 ehow is Medical Examinat must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Worceste:		City, Town or Lo Berlin					10d. Inside City Limits 1 Stres 2 □ No
	s 23s or 2	eral Dire	10e. Street and Number 25 Long Point	Court	-115 42	10f. Zip Code 21811			USA	t Country?
5-0036	ours after d	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	If Yes, specify Cuba	Specify:	(Specify Yes or No- lerto Rican, etc.)	Black, V	White etc.
21215-(	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other then "naturel", or items 23s or 28s-f show marked other then "naturel", or items 23s or 28s-f show marked other than Medical Examinar must be notified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	college (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation fu <i>ring</i> most of a )	working	Domesti	
Maryland 2121	should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Orin Joseph Mowre					Name (First, Middle, Fitzgeral		
	s 1 end 2 should of Health and Men item 27 ie marke other treumatic		19a. Informant's Name/Relationship (Richard A. Danzi,	/son	11	026 Piney			hopville,	MD 21813
altimore,	g U = L		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Salisbur	matory or other place y Cremato	ry 9/		20c. Location - City Salisbury	, MD
Bal	permit. Pag Department Important: I eny injury o		21. Signates of Funeral Service Lice	dex						Association 21804
	Physician /Medical		23a Farty Enter the disease, or companies took, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	STATIC			CAR CI		Approximate Interval Between Onset and Death
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. — Due to (or as a con:						
8760,	cate be executed by sicien and the burial-transit	dical Examiner	that initiated events 'resulting in death) Last	Due to (or as a cond	sequence of):					
P.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	n requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	V	e to the cause of death?  Probably 4 Unknown
Division of Vital Records,		Completed	05 W.						med? deat 2/S-No 1 □	e autopsy lindings available to completion of cause of h? Yes 2 No
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sion of	ding P	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Injury Work	4 🗀 IAUt 21116	g Home 5 ☐ Residence 28d. Describe he	ence 6 Other (s	Брөсіпу)
DIX	ital or Att	Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp.	ecify)			City or Town	n, State)	r Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) Z Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	vestigation, in my op	oinion, death oc	ccurred at the time, d	late and place, and	due to the cause(s)
)	2 1 1 2 2 E	<	29b. Signature and Title of ceditier	<i>&gt;</i>	~		0530	410		06
\	∫ Sta	to.	30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person and address of person and address of person address of person and address of person a	completed cause of death ( RUS 762  32. Registrar's Si	Item 23a) (Type,	Print) PROWU	0000	G. 5	411534	ry morizo,
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	/Medic		Bav.	Gara C	Da	11				ugust	31	2006	11	:50	ΑM
,	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of	Death		4c. (	County of Deat	h		
			4229 Kings Road				Edgewate				-	ne Arun	de1		
	Funeral Director		3/9-12-4201	7. Age (/	n yrs. last birti 87		If Under 1 Year Months Days	Hours	Min. 01	Date of Birth Month, Day /23/19	919	9. Birti Co Vern	un <i>try)</i>	State or	r Foreign
	and *		Usual Residence of Decedent  10a. State 10b. County	16	Oc. City, Town	orloca	ation						10d In	side City	v Limite
	tges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healin and Mental Hygiene. If if em 27 is marked other than "natural", or iteme 23a or 28a-f ehow it if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Medical Examinat must be notified at	ctor	Maryland Anne Arun		Edgewat		ALIO!							Yes	
	ith th	Director	10e. Street and Number				10f. Zip Code			1	0g. Citiz	en of What Co	untry?		
	ath w		4229 Kings Road				21037			J	Jnit	ed Stat	es		
	er de Item	Funerai		<ol> <li>Was Decedent Eve Armed Forces?</li> </ol>	er in U.S.	13. Wa	as Decedent of H Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- in, etc.)	1	<ol> <li>Race - Ame Black, White</li> </ol>		dian,	
0000	ours aft rai', or Exert	þ	1 ☐ Never Married 2 ☐ Married  3X☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		10	∵Yes 2. No	Specify:				<sup>Specify:</sup> Whi	te		
<u>ה</u>	n 72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)		(Give kil	nt's Usual Occup	durina most o	of working		16b. Kin	d of Business/l	ndustry		
7	Elementary/Secondary (0-12) College (1-4or 5+)				Homemaker					Home	e				
2	t Hyg other	Bec	17. Father's Name (First, Middle, Last)		11011			18. Mother	's Name <i>(Fir</i>	rst, Middle, M					
פופ	Ald be Aenta rked tic ev	To B	Maro W. Churchi	11				Agnes	s Prat	t					
9	and N		19a. Informant's Name/Relationship (Ty		19b.	Mailing	Address (Street				City or	Town, State, Z	ip Code	)	
` ≥	and and n 27 in 27 iner tru		Mary A. Roberts/Nic				ing Stre	et,Key	svill	e, Vi	gin	ia 2394	7		
ב כ	of Ho		20a. Method of Disposition 1 ☐ Burial 2 ☐ 3Cremation 3 ☐ R		20b. Place of cemetery	Disposit y, crema	ion (Name of tory or other place	(e)	Date		20c. Loc	cation - City or	Fown, S	tate	
Ξ	. Pages tment of t tant: If it		4 ☐ Donation 5 ☐ Other (Specify)		Kalas				-1-06			water,			
8	permit. Pages Department of I Important: If Its eny injury or o		21. Signature License	98			Name and Addres		_						
	48200	$\dashv$	23a. Part1. Enter the disease, or compli	cations that squared the	a dooth Do a		73 Solom					ater, M			
			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	/1/		1	g, such as ca	V i				Inter	oximate val Betw et and Di	reen
z	Physician /Medical		disease or condition resulting in death)		0000		y No	Len	P(3	Ruse			49	184	15
	Examiner			Due to (or as a co	onsequence o	or):							,		
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence o	of):									
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
Š	ertificate be executed ling physicien and e as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence o	of):									
	cate b	Medicai													
<b>S</b>	ding g		IF FEMALE:	3c. If yes, outcome of p	regnancy				-						
2	eath etten for u	clan	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim	Fetal death		ctopic pregnancy Other (specify)				23	3d. Date of deli-	very Day	Ye	ear
į	the d	Physician	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown	0 01 00001	000	their (specify)								
-	s that ned b	by P	Part II. Other significant conditions con	tributing to death but n	ot resulting in	the unde	erlying cause give	en in Part I.		23e. Did tob	acco us	e contribute to	the cau	se of de	ath?
3	quire an sig uld b	ed b	Hypertenois	en					_	1 🗌 Ye	s 2	No 3□Pro	bably	4 □Ur	nknown
3	aw re as be 2 sho	piet	Hyperligide	ula					Ê	24a. Was ar		24b. Were aut	oosy fir	ndings a	vailable
	The ete ha	Completed								autops perform 1 □ Yes 2	ned? No	prior to c death? 1 ☐ Yes	ompletic 2		use or
	cien: ertific ector,	Be	25. Was case referred to medical examiner?	W				26. Place o	-	eck only one			,		
5	hysi this c	ဥ	1 163 2	ospital:	2 ER/Out		3□ DOA Othe	4 🔲 INUIS				□Other (Spec	ify)		
	nding P tth. r: After i e funera	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Ti	ime of ijury	28c. Injun Work M 1 □	/at <br Yes 2∐No		Describe ho	w injury	occurred			
2	Atte	III E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	At home, far	m, street	t, factory, office		28f. L	Location (Str City or Town	eet and	Number or Rui	ral Rout	e Numb	er,
5	italo rrs aft rai Di led in	Č													
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within E4 brouns after death.  To the Funerial Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier A Cartifying Physics (Check only one)	ician: To the best of m ar: On the basis of exa and manner stated	amination and	death o	ccurred at the tim stigation, in my op	ne, date and pointion, death	place, and o occurred at	due to the ca t the time, da	use(s) a ite and p	and manner as place, and due	stated. to the c	ause(s)	
	To the To the Comp	M	29b. Signature and Ittle of certifier	1/1001		patenting to	29c. License	101	5		0//	signed (Month	/	,	
	13		30. Name and address of person who co	mpleted cause of death	(Item 23a) (T	Type, Pri	int)	()	4		- / -	1100			
			5/14ran /lessil		267	9 1	Elva +	Kd,	Ann	apolis	fell	10219	101		
	Sta Registra		31. Date filed (Month, Day, Year) <b>SEP</b> 0, 5 200	6 Registrar's	Signature	how	L	·							
			1120 12577 1 19	2011				11: 10: 10: 1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ž9, 2006 6:10 A M August /Medical Eleanor Davis 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan Year 1912 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🙀 F 94 Yrs Director 082-05-5716 New York Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be redified at Director Maryland Montgomery Rockville 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6121 Montrose Road U. S. A. Funerai 12. Was Decedent Ever in U.S. Armed Forees? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Importent: If item 27 Is marked other than "neturel", or item any injury or other traumatic event, the Mcdical Examinations. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ent: If item 27 Ie marked other than "neturel", or Itei 1 Never Married 2 Married 1 □ Yes 2 No ģ Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna Schwartz David Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart L. Mathison - Son 12401 Over Ridge Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 9/3/2006 Clarksburg, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 Rockville Pike, Rockville, Maryland Donald 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final CAR DIOMYDPATHY **Physician** 6. SCHEMIC disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and the for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Division of Vital 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred the Hospitel or Attending hin 24 hours after death. the Funerel Director: After 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 ewww. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATEL 6121 MONTROSE Registrar's Signature State Registrar

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,	State of Maryland	Department of	f Health	and Mental	Hygiene	2	0	0	6

	1 - Stete Registrer		Certificate	of Death	2. Date of Deat	eg. No.	
hysician	Decedent's Name (First, Middle, La	•			Month	Day Year	3. Time of Death
/Medical	Clarence Eugene  4a. Facility Name (If not institution, give		4h City Tou	m, or Location of Death	09 00	6 2006 4c. County of Deat	3:37 P M
xaminer	Caroline Nursing		Dent			Caroline	
rol		Sex 7. Age (In yrs.			8. Date of Birth	9. Birt	hplace (State or Foreign
ral tor		12√M 2□F 89	Yrs. Months D	ays Hours Min.	(Month, Day, June 30,	Year) Co	w York
	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
ţo	Maryland Carolin	re Ri	dgely				1 □ Yes 2 No
i Director	10e. Street and Number 11275 Cent	ral Avenue	10f. Zip Co 27 c		1	Og. Citizen of What Co United St	,
by Funerai		12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes. 2 ☐ No 194 If Yes, Give Year or Dates:	S. 13. Was Decedent If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Ame Black, White Specify: Cau	e, etc.
		ducation	16a. Decedent's Usual O	ccupation		16b. Kind of Business/	
Completed	(Specify only highest gr	ade completed)	16a. Decedent's Usual O (Give kind of work d life. DO NOT use re	one during most of won stired)	king		
mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Self-employe			Constructi	on
40	17. Father's Name (First, Middle, Last	)		<del></del>	e (First, Middle, M	Maiden Sumame)	
To B		r Davis		Edna N	esbitt C	artwright	
	19a. Informant's Name/Relationship (		19b. Mailing Address (St				Tip Code)
	Eloise Davis / u	vife	11275 Cent	ral Ave., R	idgely,	MD 21660	
	20a. Method of Disposition		Place of Disposition (Name of emetery, crematory or other	1		20c. Location - City or	Town, State
١,	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control	THemoval from State	itol Cremato		7/2006	Dover, DE	
	21. Signature of Funeral Service Lice	P. Moore	MOORE Fune	ddress of Facility PA,		dSt., Denton,	MD 21629
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	aplications that caused the death	h. Do not enter the mode of	dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Immediate Cause (Final	e 1	A A				Onset and Death
b	disease or condition resulting in death)	a. Due to (or as a consequ	dar ca	reinom	4		morrhs
		,					
Je.	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that is unterested to the cause (Disease or injury)	b. Due to (or as a consequ	uence of):				
Examin	Cause (Disease or injury that initiated events	c					
EX3	resulting in death) Last	Due to (or as a consequ	uence of):				
edicai		_ d					
led	I I I I I I I I I I I I I I I I I I I						
Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		ancv		23d. Date of deli	•
sicis	in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregnant at time of de				Month	Day Year
hys	9 Unknown						
by P	Part II. Other significant conditions	contributing to death but not rest	ulting in the underlying cause	given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ed	LHF				1 □ Ye	es 2□No 3□Pro	obably 4 Unknown
Completed	COPO				24a. Was ar	n 24b. Were au	topsy findings available
E					autops:	y prior to death? ned? death? 2 No 1 ☐ Yes	completion of cause of
0	25. Was case referred to medical			26. Place of Dear	1 ☐ Yes 2 th Check only on		20,10
0.0	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1  Inpatient 2	ER/Outpatient 3□ DOA	0.1		nce 6 □Other (Spe	cify)
Ë	27. Manner of Death	28a. Date of Injury		njury at Work?		w injury occurred	//
atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	( <i>Month, Day</i> Year) n		Work? 1 □ Yes 2 □ No			
Hicz	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At no	ome, farm, street, factory, of	ice		reet and Number or Ru	ral Route Number,
Certification:	4   Nothicle	building, etc. (Specify			City or Town		
edicai	29a. Certifier Certifying Pl (Check only one) 2 Medical Example	nysicien: To the best of my kno- miner: On the basis of examinal and manner stated.	wledge, death occurred at the tion and/or investigation, in r	e time, date and place, ny opinion, death occur	and due to the ca red at the time, da	ause s) and manner as ate and place, and due	stated to the cause(s)
ž	29b. Signature and title of certifier	Vi un	1 _	ense number		9d. Date signed (Mont)	n. Day, Year)
	- 70V	H MD	D	$\infty 47534$		9/7/	06
	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	1	10	21629	
	ZUKI MI	LIKET STIA	c+ $Der$	17/1/ /l			
tate	31. Date filed (Month, Day, Year)	32: Registrar's Signa		17011, 1		21021	
State jistrar	31. Date filed (Month, Day, Year) SEP 7 201	ili.	ture	1701, 1		21021	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 29997 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas W. September 14,2006 1:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign M 2□ F 577-36-1427 78 Director March 11.1928 Washington.DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Example must be notified at 1 ☐ Yes 2XCXNo Director Maryland Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4928 Lerch Drive 20764 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No1950-If Yes, Give Year or Dates: 52 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: if item 27 is marked other than "natural", or Ite 1 Never Married 2 T Married 1 ☐ Yes 2 🗓 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Inspector Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas H. Dudley Margaret Holloran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Dudley / Wife 4928 Lerch Dr., Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 09/25/2006 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: if any injury or once. injury or Arlington, VA Arlington National Cem. 21. Signature of uperal Service Livensee George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, Md 21037 23a. Part I Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmoning Physician 15 40415 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Right Heart Fai 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔁 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 (2) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D38563 September 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWENSVIlle ROAD, West River, MO 13 134 Wayne 0. 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Registrar SEP 21 2006

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2200 M Oneida Louella Elliott 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 28, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1 M 2 X F 213-14-6562 Yrs. 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'naturel', or items 23a or 28a-f show other treumatic event, the Medical Examiner was be nutified at 1 ☐ Yes 2 No Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12107 Ocean Gateway 21842 US Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "I Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Hospitality Service .O.B. 05/28/1921 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 shoutd but of Health and Menta: If item 27 is marked Roland F. Watson Flora Mae Bowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Derrickson 12615 Collins Rd.,Bishopville, Md. 21813 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 9-11-2006 \* 4 ☐ Donation 5 ☐ Other (Specify) Berlin, Maryland 21. Signatur f Fun Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md., 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death neumonia ASPIRATION Physician 7 days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Er for John of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown NONE Completed Elliott, Oneida 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Da e of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Grentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atlunk General Hospital 9733 Heath was BA 6 PLAZAAK ENIOLA 31. Date filed (Month, Day, Year) State SEP 0 8 2006

DHMH 17 Rev 1/200

			For State	State of Ma	-	artment of He		-	ne No.200	6 29999
	-		Registrar  1. Decedent's Name (First, Middle, Last)			timouto or D		2. Date of Death		3. Time of Death
-	Physici /Medic		Keith Eugene Edn	AV				Scatour 6 4	Day Yes	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death	,	4c. County of D	eath
			Vulou Hospital		1 County	Elictor			Cecil	
L	Funeral Director		5. Social Security Number 6. Security Number 219-60-7940	M 2 F	(In yrs. last birthday) 52 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 03/05/1	ear)	Birthplace (State or Foreign Country) [ennesee
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f sho	ţō	Maryland Cecil		E1kton					1 ☑ Yes 2 ☐ No
	ath with the Marylan 23s or 28s-f show	Director	10e. Street and Number		EIRCOII	10f. Zip Code		10g.	. Citizen of What	Country?
	23a c		242 West High Str	eet		21921			United	States
	items items	Funerai	11. Wastar Status	12. Was Decedent Ev Armed Forces?	1	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	त ठेड	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. Navy	1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
9	72 hours "natural",		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupation	on	168	b. Kind of Busine	ss/Industry
21215-0036		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	life.	kind of work done dur DO NOT use retired)	ing most of work	ing		
12			12 17. Father's Name (First, Middle, Last)		Ta	xi Cab Dri		e (First, Middle, Mai	Taxi	
Maryland	d tal	o Be	Bobby Edney			"		Hensley)		
ary	d 2 should be th and Menta 7 is markad traumatic ev	ို	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street and	-			e, Zip Code)
	オトトル		Marie Edney /W	ife	24	2 West Hig	h Stree	t Elkton.	MD 219	21
Baltimore,	8 4 -		20a. Method of Disposition		20b. Place of Dispo			Date 20d	c. Location - City	
Ë	Pages tment of tant: If it ijury or o	4	1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)			le Cremato		ember	Newark,	DE
Bal	permit. Page Department of Important: If any injury or once.		21. Signatule Funeral Service Lice			2. Name and Address	Cr	ouch Fune	ral Home	
			23a Part1. Enter the disease, or compli	cations that caused t	he death. Do not en	27South Ma	in Stre	et North or respiratory arrest,	East, MI	Approximate
	Pnysician	VS 13	shock, or heart failure. List only or Immediate Cause (Final			0	wales.	. January		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	endocrine	1941199	4121		O MONTO
E	Examiner		Sequentially list conditions,							
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to for as a	consequence of):					
Ć,	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last		consequence of):					
8760,	The law requires that the death certificate be executed tae been signed by the attending physician and oate 2 should be detached for use as the burial-transit	dicai		i						
9	artifica ing ph e as th	Med	IF FEMALE:						T	
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Ö.	t the de by the tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	me or death St					
Δ.	res that thi igned by be detac	by Pr	Part II. Dther significant conditions cor	ntributing to death but	not resulting in the u	nderlying cause given	in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ords	v require been sig should b	ed t	severe Hype	rcalcen	14			1 🗆 Yes	25440 3□	Probably 4 Unknown
of Vital Records,	e law requ has been je 2 shoul	Completed	Superior Vena	Lava Sy	idone			24a. Was an autopsy	prior	autopsy findings available to completion of cause of
E B		Con						performed 1 ☐ Yes 2		es 2□ No
Vita	Physician: this certificantal director,	o Be	25. Was case referred to medical examiner?	lospital:				h (Check only one)		
of		-	1 Yes 2 4 No	1 thpatien 28a. Date of Injury	28b. Time o	f 28c. Injury a		me 5 Residence 28d. Describe how		pecify)
ion	ottending I death. ctor: After y the funer	ation	1 Datural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work? M 1 ☐ Ye	s 2 No			
Division	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	urs oral	65	29a. Certifier 1 Certifying Physical Certification Physical Certification Physi	sician: To the best of	my knowledge, deat	h occurred at the time,	date and place,	and due to the caus	se(s) and manner	as stated.
	To the Hosp within 24 ho To the Fune completely fi	edic	(Check only 2 Medicel Exami	ner: On the basis of e and manner state	examination and/or in ed.	vestigation, in my opin	ion, death occur	red at the time, date	and place, and o	lue to the cause(s)
	To To	Σ	29b. Signature and title of certifier	1100		29c. License n	C / G T	29d.	Date signed (Mo	onin, Day, Year)
			30. Name and address of person who co	ompleted cause of de-	ath (Item 23a) (Tune	Print)	, , , ,	1) (	CHIKA O C	0 2000
	1+ 1 VA		Alfred A Pirro	, MO	106 Bo	w Stree	7 81	sctoy 1	MO 2.	onth, Day, Year)  5 2006
	Sta		31 Date filed (Month Day Year)	32. Registrar	's Signature	book				
	Regist	al	OL: OL	The state of the s						

State of Maryland / Department of Health and Mental Hygiene Reg. No 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vear 6:38 A M ELBERT SEPT 2006 **ESHAM** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11647 BACK CREEK ROAD BISHOPVILLE WORCESTER 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
APR. 25, 19 Birthplace (State or Foreign Country) **Funeral** Days Yrs Director 218-12-1855 85 APR. MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "natural", or Itama 23a or 28a-f show any injury or other traumatic event, If a Madical Examiner must be presented. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No MARYLAND WORCESTER BISHOPVILLE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 11647 BACK CREEK ROAD 21813 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FARMER 8 AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DANIEL **ESHAM** EVA Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11647 BACK CREEK ROAD, BISHOPVILLE, MARYLAND 21813 ELIZABETH V. ESHAM/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) BISHOPVILLE CEMETERY 9/6/06 BISHOPVILLE, MARYLAND 21. Signatur de uneral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Parri . Enter the disease, or complications that ca shock, or heart failure. List only one cause on pa used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, efficie. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MALO /Medical Due to (or as a consequence of Examiner Muscary. Sequentially list conditions, if any, reading to infine diate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a sonsequence of) The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown n signed by th 1 be def 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown hould b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ce ificate has autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home Residence 6 Other (Specify) s after death.
sal Director: After this c ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier Medical 1 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) VITON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 food St. Suite 605, Salishung Md. 21804 0 teven M.D ear 106 31. Date filed (Month, Day, Year) gistrar's Signature State 6 Registrar